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ABSTRACT

This conference proceedings document includes 43 papers on the provision of mental health services to children. Eleven papers focus on evaluation of systems of care, addressing: preliminary findings from several program evaluation studies, systems of care in California, several Robert Wood Johnson projects, a parents' satisfaction survey in Colorado, comprehensive services and prevention, multicultural issues, and innovative neighborhood-based approaches. Five papers discuss the organization, staffing, and financing of systems of care. These papers consider state financing strategies to promote home-based and community-based services, workforce issues related to community-based services, residential treatment programs in Florida, embeddedness and resource transfers between agencies, and the role of cash subsidies. Program evaluation is the focus of six papers considering issues of children's in-home psychiatric emergency services, family reconciliation services, a home-based mentor program, community-based programs, qualitative evaluation of community-based prevention programs, and multisystemic treatment with adolescent offenders and substance abusers. Eight papers look at the role of education in systems of care. These papers discuss: the school-based wraparound approach, three demonstration projects in Texas, a primary prevention and early intervention demonstration project, attitudes of teachers and students toward mainstreaming, and attitudes of parents toward collaborative educational teams. The final section presents five papers on child welfare/foster care systems. They address: factors influencing appropriate placement, treatment foster family care, an individualized system of care and juvenile delinquency, the use of aggregated progress indicators to evaluate treatment foster care, and integrating research into practice in a public welfare agency. Most papers contain references. (DB)

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The 6th Annual Research Conference Proceedings

ED 372 523

A System of Care for Children's Mental Health: Expanding the Research Base

March 1 to 3, 1993
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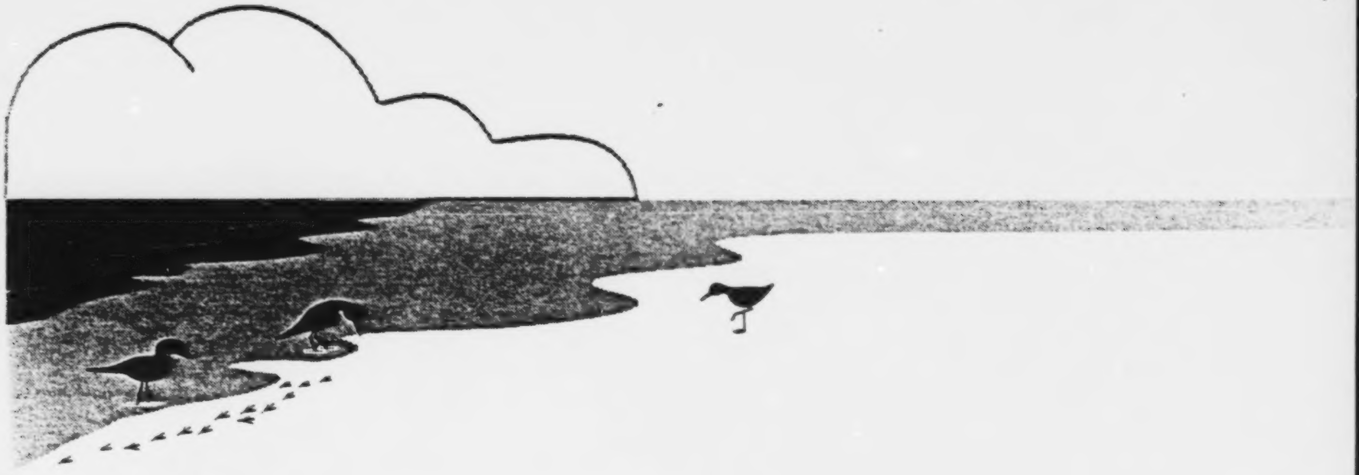

The 6th Annual Research Conference Proceedings

A System of Care for Children's Mental Health: Expanding the Research Base

March 1 to 3, 1993
Tampa, Florida

Editors:
Cindy J. Liberton
Krista Kutash, Ph.D.
Robert M. Friedman, Ph.D.

Published by:
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Florida Mental Health Institute, University of South Florida

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Preface

It gives us great pleasure here at the Research and Training Center for Children's Mental Health to publish the Proceedings from our sixth annual research conference.

We offer the Proceedings with a special thanks to the researchers and evaluators who presented their work at our conference, and who have allowed us to include their work in our Proceedings. We especially applaud their efforts because we recognize that research on service delivery and systems of care is not only complex conceptually and methodologically but is frequently fraught with the difficulties that come from working outside of a controlled setting.

During recent years, as the mental health needs of children have become more apparent, and as the need for system reform has also become more apparent, many talented researchers and evaluators have lent their expertise to the effort to learn how to best organize systems so that they serve children and families well. Often working in partnership with parents, providers, policy-makers, and administrators, these researchers and evaluators have taken a relatively new field of scientific inquiry and advanced it tremendously in just a few years.

I would like to dedicate this Proceedings to my friends and colleagues who have chosen to contribute to the well-being of children and families through practical, applied research on service delivery and systems of care. Their contributions to policy development, and system and service change have been substantial and, I am confident, will continue to serve children well for many years.

I would also like to use this occasion to thank our wonderful team of people here at the Florida Mental Health Institute, the host organization for the Research and Training Center, for their outstanding efforts in support of our annual conference, the Proceedings, and our overall research and training efforts.

Cindy Liberton has taken the lead in preparing the Proceedings, and has done an excellent job in her usual gracious style. Special thanks also to Co-Editor and Deputy Director for the Center, Krista Kutash, for her leadership both with the conference and the Proceedings. Thanks, too, to Al Duchnowski, also Deputy Director for the Center, and our other Center staff. This includes Melinda Allegar, Eric Brown, Rusty Clark, Rita Esposito, Paul Greenbaum, Kim Hall, Sharon Lardieri, Cheryl Maury, Larry Minnick, Mark Prange, Vestena Rivera, Deborah Rugs, Teresa Strong, and Denise Wilson. It also includes our new additions, Kathy Armstrong, Lynn Foster-Johnson, Mario Hernandez, Linda Roebuck, and Amy Pugh, and our former team members, Corrine Gaertner, Jan Green, Mike Johnson, and Evelyn Milton.

We were also very fortunate to have the assistance of our Communication Unit in conducting the conference and preparing the Proceedings. I am very pleased to thank Kathy Anthony, Dan Casella, Lucy Doyle, John Eckhardt, Yvonne Johnson, Cindy Liberton, Terry Nyberg, Bonnie Rogers, Irma Rubin, Steven Roggenbaum, and George Shuttleworth. Other FMHI staff who have been extremely helpful include Tim Alberts, Patty Cleveland, and Elissa Henderson.

As always, our Center Advisory Board, under the leadership of Christina Kloker Young of Stow, Ohio, has been tremendously supportive of our efforts. We appreciate the time that our Advisory Board members contribute to helping our Center achieve its mission. We also appreciate the support of the administration of the Florida Mental Health Institute, led by Dean Max Dertke, and our wonderful partners in the federal government, including Judy Katz-Leavy and Diane Sondheimer of the Center for Mental Health Services and Roseann Rafferty of the National Institute on Disability and Rehabilitation Research.

Robert M. Friedman, Ph.D

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Monday, March 1, 1993

8:00 AM - 9:00 AM
Audubon Foyer

Registration and Continental Breakfast

9:00 AM - 9:15 AM
Audubon ABC

Welcoming Remarks

Robert M. Friedman, *University of South Florida, Tampa, FL*

9:15 AM - 10:30 AM
Plenary Session
Audubon ABC

The Effect of Violence on Children's Mental Health

Hope Hill, *Howard University, Washington, DC*; *Discussants:* Karl Dennis, *Kaleidoscope, Chicago, ILL;* Barbara Huff, *Federation of Families, Alexandria, VA*

Dr. Hill will describe her own research on the effects of violence on the emotional well-being of children, and will summarize the overall research in this area She will also explore the implications for mental health systems of this body of research, and of the increasing incidence of violence.

10:45 AM -12:15 PM
Session 1
Audubon B & C

Symposium

Follow up of Adolescents with Severe Psychiatric Impairment into Young Adulthood

Ann Vander Stoep, Linda Holcomb and Jennifer Taub, *Seattle Children's Home, Seattle, WA*

The McGraw Center Follow-up Study was designed to document the psychosocial course of a cohort of youth discharged from residential psychiatric treatment. The study uses a longitudinal, repeated measures design with interviews at 6 months, 1, 2, 3, 4, and 5 years post discharge. Interviews include measurements of life course, quality of life and psychopathology. The relationship between outcome measures and factors such as diagnosis (thought, affective, conduct), gender, age at follow up, substance abuse history, history of abuse, path of entry into residential treatment, progress made in residential treatment, and family involvement in treatment will also be examined. Finally, implications for service planning and future research will be discussed.

Transition of Severely Emotionally Disabled Youth to Adulthood

Mieko K. Smith, *Cleveland State University, Cleveland, OH*

The paper will disseminate findings of a longitudinal study of mental health and other services received or not received by high school students with mental and emotional disorders, based on the first year data. The study also examines how the students' transition from childhood to adulthood with the sample of high school students in the Severely Behaviorally Handicapped (SBH) program and Transitional Adjustment Program (TAP) in all high schools in a northeastern county of Ohio.

Monday, March 1, 1993

Who Fares Best? Comparing Outcomes for Young Adults Served in Special Education and Residential Settings

Starr E. Silver, *University of South Florida, Tampa, FL*

An in-depth investigation of the transition process was conducted with a subsample of participants in the National Adolescent and Child Treatment Study (NACTS). Participants were either in residential treatment or community based special education classes when NACTS began. Outcomes for these two groups will be described and compared to the data presented by A. Vander Stoep and M. Smith.

10:45 AM -12:15 PM
Session 2
Snowy Egret

Symposium

Evaluation of the Robert Wood Johnson Foundation Mental Health Services Program for Youth at Mid-Project

Judith K. Gardner, *Brandeis University, Waltham, MA*, Leonard Saxe, Gretchen S. Lovas and Amy Glass, *Brandeis University, Waltham, MA*

The Robert Wood Johnson Foundation Mental Health Services Program for Youth (MHSPY) is designed to implement the concepts of coordinated, comprehensive and appropriate care for the costly and "noisy" population of children and adolescents with severe emotionally disturbances and their families. This symposium will include four presentations. The first will discuss the questions that underlie the evaluation of the MHSPY demonstration. It will describe the evaluation logic model and the various methodologies being used by the evaluation. The second will compare the projects once they begin actual implementation. This will be followed by an analysis of the process of implementation at three of the sites at mid-project, comparing levels within sites (state and local administrative and service provision) as well as across the three sites. This analysis will be based on the categorization of "key issues" (major themes) expressed during observations and interviews of collaborative working groups as they illuminate key dimensions of the demonstration. The symposium will conclude with a discussion of the synthesis of the different methodologies used in the evaluation and a presentation of the "gestalt" of the site that results from the synthesis.

10:45 AM - 12:15 PM
Session 3
Sand Hill Crane

Utilization of Mental Health Services in a Tri-Ethnic Sample

A. J. Pumariega, *University of South Carolina School of Medicine, Columbia, SC;* C. E. Holzer and H. Nguyen, *University of Texas Medical Branch, Galveston, TX*

Although there has been an increasing interest in the utilization of mental health services for children, little attention has been given to the utilization of such services by minority children. This growing population lacks access to services not only due to their scarcity, but also due to their lack of finances and the lack of cultural competence of these services. In this study of 2092 junior and senior high school students from two diverse regions in Texas (the lower Rio Grande Valley and Galveston County), the utilization of mental health and medical services as well as ethnicity and total behavior problem levels were examined. The findings suggest that availability of services plays a major role in service utilization in minority youth, but cultural differences may also play a significant role as witnessed by the much lower rate of hospital utilization of African-Americans.

The City Lights Model: Primary Prevention and Early Intervention

Bert L'Homme and William D. Evans, *City Lights School, Washington, DC*

This paper summarizes the City Lights primary prevention and early intervention project. The project's practical objective is to prevent drug abuse and unemployment among African American adolescents expressing severe emotional disturbance through comprehensive primary prevention and early intervention. Its ultimate goal is to increase the number, effectiveness, and fiscal self-sufficiency of similar programs nationwide. The paper presents outcome data and argues that the provision of comprehensive social services to at-risk African American youth with severe emotional disturbance, with severe emotional disturbance cannot succeed without comprehensive academic, clinical, vocational, and substance abuse prevention interventions.

The Multicultural Child & Family Development Project (MCFDP): Evaluating the Development of Innovative Neighborhood Based Approaches for an Integrated Service Delivery System

Richard Briscoe, *University of South Florida, Tampa, FL*

The Multicultural Child and Family Development Project (MCFDP) provides technical assistance to neighborhood based organizations to improve service delivery for ethnic minority children and families. The MCFDP conducts research and program evaluation activities in order to determine the impact of program intervention strategies on these target populations. This paper describes the framework used in developing a formalized integrated service delivery system within innovative neighborhood programs in low income housing developments. Presented is research and program evaluation strategies aimed at increasing program effectiveness. The data presented emphasize measurable outcomes as well as process activities to achieve those outcomes. The MCFDP analyzed program data relating to program goals, objectives, activities and outcomes.

10:45 AM - 12:15 PM
Session 4
Wilson's Plover

A Comparison of Level of Functioning in Children and Adolescents as Judged by Trained Interviewers and Parents

Wm. Thomas Summerfelt, *Vanderbilt University, Nashville, TN;* Kay Hodges, *Eastern Michigan University, Ann Arbor, MI;* Leonard Bickman, *Vanderbilt University, Nashville, TN*

Legislators and mental health administrators who make decisions about budget allocations tend to place more weight on level of functioning as an indicator of need for services or success of an intervention. A problematic issue in children's mental health services research is the lack of variety in choosing outcome measures to assess mental health consumers' level of functioning or degree of impairment in carrying out everyday tasks. Hodges, Ring-Kurtz, and Reiter (1991) have developed a multi-dimensional functioning scale called the Child and Adolescent Functioning Assessment Scale (CAFAS). A parent version of the CAFAS was developed and administered to 100 parents. Trained interviewers also completed the CAFAS with no knowledge of parental ratings. Agreement on overall functioning was assessed. Differences were investigated and described.

Colorado's Parent Satisfaction Survey: Policy Implications for a Local System of Care

Michael H. Moynihan, John R. Forward and Brad Stolbach, *University of Colorado at Boulder, Boulder, CO*

Findings from a survey of 96 Colorado parents of children and adolescence with severe emotional disturbance will be presented and discussed. These will include local service needs assessments, actual use and satisfaction. Parent-Professional relations, parent support groups and interagency issues will be discussed.

The "Agency Consumer Evaluation" (ACE): Use of Quality Improvement Techniques to Enhance Inter-Agency Relations

Robert Sewell, *Individualized Services Consulting, Juneau, AK*

In recent years, an increasing focus on inter-agency collaboration has occurred. Concurrent with the rise of inter-agency collaboration has been the increasing focus on the critical role of the "customer" in the identification of those services which are desired and effective. The proposed paper will present a method for agencies to use when seeking routine feedback regarding their overall performances as seen by their "allied" or "sister" agencies. This method is termed the Agency Consumer Evaluation and appears to offer utility for varied human service organizations. The method yields an array of quantitative and qualitative information useful in guiding an agency toward becoming continually more responsive to those it serves. Actual demonstration data were gathered in a large, rural community mental health center and will be provided for purposes of illustration.

12:15 PM -1:45 PM *Lunch on your own*

1:45 PM - 3:15 PM
Session 5
Audubon B & C

Resource Transfers Between Agencies Caring for Children's Mental Health: A Panel Study of Facilitating Conditions

Thomas Schott, *University of Pittsburgh, Pittsburgh, PA*

What conditions facilitate the transfer of resources, such as funds, information and clients between agencies caring for children's mental health? This presentation will discuss a survey of resource transfers and other relations between the agencies in systems of services for youth with serious emotional disturbances. Various kinds of resource transfers were found to be affected by different conditions. Specifically, an agency's acquisition of information from another agency is enhanced by the perceived effectiveness of the relationship between them; an agency's receipt of clients from another agency is promoted by its receipt of information from the other agency and by the consensus between them; and an agency's receipt of funds from another agency is increased by the perceived effectiveness of their relationship; and all three are reinforcements over and above existing transfers.

The Implementation and Evaluation of Innovative Coordinated Systems of Care for Children and Adolescents: The Contributions of the Public-Academic Liaison to Improving Mental Health Services for Children and Adolescents

Leonard Bickman, *Vanderbilt University, Nashville, TN;* Beth Dague, *Starke County Community Mental Health Board, Canton, OH;* Kathleen A. Maloy, *Vanderbilt University, Nashville, TN;* Linda O'Neil, *Tennessee Commission on Children and Youth, Nashville, TN;* Wendi Smith, *Center for Mental Health Policy, Vanderbilt University, Nashville, TN;* Nancy Thomas, *Office of Children's Service Administration, Nashville, TN*

This session describes the implementation and evaluation of two innovative coordinated systems of care for children and adolescents. The role of investigators in an academically based research center in evaluating and informing the real world process of reforming systems of care for children and adolescents with serious mental health problems. The first project involves a single county in one state, Stark County, Ohio, that has developed an innovative demonstration program to provide comprehensive and managed services to children with severe emotional disturbances. The second project involves the development and implementation of a statewide system of care, the Tennessee Children's Plan that makes significant changes in the way the State of Tennessee finances and manages children's services.

Evaluation of the Mental Health Initiative for Urban Children: A Program of the Annie E. Casey Foundation

Robert Friedman, *University of South Florida, Tampa, FL;* Judith Meyers, *Annie E. Casey Foundation, Greenwich, CT;* Krista Kutash, *University of South Florida, Tampa, FL*

This initiative is a five year, neighborhood-scale program which seeks to demonstrate new ways of delivering culturally appropriate, family-sensitive mental health services to urban communities and to work with states to improve the policies and practices supporting these services. An overview of the program and the evaluation strategy will be presented.

Monday, March 1, 1993

1:45 PM - 3:15 PM
Session 6 — Symposium
Snowy Egret — ***Creating a New System of Care: Building a Stronger Child and Family Partnership.***

Ivor D. Groves, and Starr E. Silver, *University of South FL*; David L. Fairbanks, *SEDNET Project, Tallahassee, FL*

This paper evaluates characteristics, predictors, and prevalence of problems among children and families involved in the foster care system. Particular analysis is made of the movement pattern of children into different living arrangements and the efficacy of permanency planning. This evaluation addresses children and families currently associated with a state public service system. It describes the data from 2,933 children recorded in a Child Welfare data system, 2,933 caseworker surveys, 225 Achenbach Child Behavior Checklists, 100 case record reviews, 53 individual case studies, desk audits, and Family Preservation data from 6 counties.

1:45 PM - 3:15 PM
Session 7 — Symposium
Sand Hill Crane — ***If We Know So Much, Why Are Things Still So Bad: What's Wrong With the Research Agenda and How Can It Be Fixed***

Phil Leaf, *John Hopkins University, Baltimore, MD;* Albert Duchnowski, *University of South Florida, Tampa, FL;* Reginia Hicks, *Maryland Division of Mental Hygiene, Baltimore, MD;* Kimberly Hoagwood, *National Institute of Mental Health, Rockville, MD;* Barbara Huff, *Federation of Families, Alexandria, VA;* Kelly Kelleher, *University of Arkansas, Little Rock, AR;* John Landsverk, *San Diego State University, San Diego, CA*

During the past decade, there has been a significant increase in the quantity and quality of research on psychiatric disorders in children and why do so few children seem to be benefiting from our knowledge? Researchers, state planners, and family members will make brief presentations focusing on the role of the pediatricians in the delivery of services to children with severe emotional disturbances, mental health service needs of children in foster care, the role of schools in the provision of mental health services, under served populations from the perspective of state policy makers, and the failure of researchers to appreciate the perspectives of parents and advocates. We propose to leave 30 minutes for discussion of presentations by those attending the session.

1:45 PM - 3:15 PM
Session 8
Wilson's Plover — ***Home-Based Services for Children with Serious Emotional Disturbance: An Analysis of Consumer and Program Variables Associated With Positive Outcomes.***

Marcia G. Toprac, Lawrence W. Rouse, Mark Mason and Susan Burek, *Texas Department of Mental Health and Mental Retardation, Austin, TX*

This paper utilizes data from five home-based demonstration projects in Texas to address the question of which children and families benefit most from the intervention of home-based services for children with severe emotional disturbance. The evaluation design is briefly described, as are the general program outcomes. The paper focuses primarily upon the results of a series of univariate analyses and stepwise multiple regressions which explore the pattern of relationships between child, family and program characteristics and program "success", measured in terms of avoidance of out-of-home placements and change in intensity of behavior problems.

Correlates of Post-Treatment Outcomes for Children Receiving Family-Based Mental Health Services

Martha M. Dore, *Philadelphia Child Guidance Clinic, Columbia University School of Social Work, Philadelphia, PA*

This paper presents findings from a study of over 1000 families who have participated since 1988 in family-based children's mental health services across Pennsylvania. It will focus specifically on demographic, descriptive and family functioning variables which correlate highly with post-treatment outcomes. Relevant outcomes include psychiatric in-patient and residential placement, emergency room contact for mental health problems, as well as involvement with other child-serving systems such as child welfare and juvenile justice. These finding begin to address the differential effectiveness of family-based services and identify those families and children best served by this model of mental health care.

Family Support Programs Using a Cash Subsidy to Meet the Needs of Families of Children with Emotional or Developmental Disabilities

Robert Goerge and Ruth Osuch, *University of Chicago, Chicago, IL*

For the past two years, the Illinois Department of Mental Health and Developmental Disabilities has funded a non discretionary cash subsidy program to a small number of randomly selected families of children with severe emotional disorders or developmental disabilities. This program has given families the opportunity to identify and prioritize their needs and the flexibility to determine how these needs should best be met. Evaluation findings from a two year longitudinal study including family and child characteristics, service needs, level of stress, family support network, and out-of-home placement plans will be presented. Particular attention will be paid to program impacts and ways in which the families utilized the money. Drawing from the Illinois experience, policy implications of using a case subsidy model in contrast to a more traditional family support program which utilized existing services through a case management model will also be discussed.

3:15 PM - 3:30PM ***Break***

Monday, March 1, 1993

3:30 PM - 5:00 PM
Session 9
Audubon B & C

Symposium

Perceptions of Parents, Educators, and Students Regarding the Inclusion of Students With Serious Emotional Disturbance in Regular Classrooms

Ruth Walker Hamilton, Julie Welkowitz, Karen Topper and Linda Inatsuka, *The University Affiliated Program of Vermont, Burlington, VT;* and Susan Yuan, *University of Vermont, Burlington, VT*

Students served by the Utilization of Best Educational Practices for Students with Severe Disabilities Program are either at risk of removal from their local schools or are returning to them. A qualitative investigation was conducted pre-post to examine perceptions of educators, parents, peers, and the student about issues pertaining to inclusion of students with Severe Emotional Disturbance (SED). By listening to parents, educators and students it was possible to gain a better understanding of factors associated with including students with SED and to identify effective interventions and experiences that can facilitate inclusion. The results will include the perceptions of: 1) students with SED; 2) the student's peers; 3) educators; and 4) parents about inclusion of students with serious emotional disturbance in the regular classroom.

3:30 PM - 5:00 PM
Session 10
Snowy Egret

Research in a Public Agency Setting: A Model for Data Based Organizational Change

Diana J. English and Sophia Giles, *Office of Children's Administration Research, Seattle, WA*

This paper will present a model for data based organizational change in a public agency setting. The organizing principle of data based organizational change is that administrators and managers need information on which to base policy development and to guide program change. The general approach to research is a philosophy that the data must have direct relevance to current issues in child welfare as well as direct implications of applications to the delivery of social services in public or private agency settings. The paper will discuss methods for financing, staffing, relationships to organization, development of research questions, outcomes for data, and integration of findings.

"A New Way of Caring": A Collaborative Approach to Keeping Kids in the Community, at Home, in School and Out of Trouble

Abner J. Boles, Miriam Martinez and Larry S. Marx, *City and County of San Francisco, Department of Public Health, San Francisco, CA*

The Family Mosaic Project is one of eight demonstration programs funded in part by the Robert Wood Johnson Foundation to develop a Health and Human Service System of Care for children and adolescents with severe emotional and/or behavioral disorders. The Family Mosaic Project is a demonstration project intended to provide intensive case management and comprehensive flexible services in an urban setting. Three indicators have been identified as potential predictors of improved functioning for children and youth with severe emotional disturbances. Outcome data with regard to these three indicators will be reported. Factors that may directly contribute to an impact of these indicators will be examined. The interaction of these factors and the identified predictors will be explored.

Principles of the Development of Local Systems of Care

Ira S. Lourie, *Human Service Collaborative, Washington, DC*

This paper reports on the study of 15 communities in which there had been some development of local systems of care for children and adolescents with severe emotional disturbance. Close to half of these communities had been identified as having model systems, while the others were visited as part of various consultative processes. One to two day visits to these sites led to the identification of several principles of local system development. The data from the sites was analyzed to determine the validity of these principles. This paper describes the principles as they were demonstrated by the sites, the process of their validation, and the implications for the funding of the future demonstration projects.

3:30 PM - 5:00 PM
Session 11
Sand Hill Crane

"Unclaimed Children" Revisited: The Status of State Children's Mental Health Services

Maryann Davis, *Charles River Health Management Inc., Brighton, MA;* Susan W. Yelton, *University of South Florida, Tampa, FL;* Judith Katz-Leavy, *Child and Adolescent Service System Program, Washington, DC*

Jane Knitzer's "Unclaimed Children" (1982) described continued nationwide failure to provide services for children and adolescents with severe emotional disorders. Since Knitzer published her study, there has been considerable change in the philosophy, administration and operation of services for children with serious emotional disturbances The current study is the first to summarize the status of children's mental health systems, state by state, since 1982. Information was obtained from state mental health plans and telephone interviews with state heads of children's mental health services. Summary and comparative results to be presented will include the organizational context of state childrens mental health agencies, state visions for and progress towards a system of care, pertinent legislation, and current gaps in service systems. Results will also be compared to those documented by Knitzer in 1982.

Mental Health and Homeless Adolescents: Preliminary Findings

Charles J. Morgan, Elizabeth Moore and Kathryn Wurzbacher, *Youth Care, Seattle, WA*; Sandra Tomlin, *Seattle Mental Health Institute, Seattle, WA;* A. M. Cauce, *Department of Psychology, University of Washington, Seattle, WA*

As part of a study of the effectiveness of case management, homeless youth, ages 13 to 21, were administered selected modules of the Diagnostic Interview Schedule for Children (DISC, version 2.1c). Preliminary analysis of the first 100 DISCs indicate that about two thirds of the participants meet the criteria for at least one DSM III-R diagnosis. Half meet the criteria for at least one DSM III-R diagnosis. Half meet the criteria for conduct disorder, a third meet the criteria for major depression, and roughly a tenth satisfy the criteria for schizophrenia. These results are comparable to those obtained by Greenbaum et al (1991) in a comparable assessment of adolescents living at home but already judged to meet the criteria for serious emotional disturbance. They are very different from results obtained in normative populations (Kashani, et al. 1987).

State Financing Strategies Used to Promote Home and Community-Based Services for Children with Serious Emotional Disturbances and Their Families

Krista Kutash, Vestena Robbins Rivera and Kim Hall, *University of South Florida, Tampa, FL*

This presentation describes the results of a national survey conducted with state directors of children's mental health services to gather information regarding 1) a state's level of agreement with various financial principles of home and community-based systems of care and 2) the extent to which financial policies and procedures were currently being used by a state to maximize home and community-based mental health services for children. Implications of these findings as well as areas for further research will be discussed.

3:30 PM - 5:00 PM
Session 12
Wilson's Plover

Two-Year Findings from a Longitudinal Study Across Three Demonstration Sites in Texas: The School of the Future Project

Scott S. Keir, Ralph E. Culler and Pamela Diamond, *University of Texas at Austin, Austin, TX*

For the past two years, data have been collected annually from schools participating in the School of the Future demonstration sites in Austin, Houston, and San Antonio, Texas as well as demographically-matched comparison schools in these same cities in Texas. Survey instruments measuring self-esteem, mental and physical health, and school climate have been administered to students in these six middle schools. Teacher-reported data assessing the mental and physical health of students have also been collected in the nine elementary schools. Achievement and attendance data have been matched with corresponding student survey information. This paper focuses on the profiles generated from the baseline data collection and the changes that occurred in these profiles through the second year of the project.

A Study of the Attitudes of Regular Teachers and Administrators Toward Mainstreaming (Inclusion)

Claudia S. Greene, *South Carolina State Department of Education, Columbia, SC*

The purpose of this study was to investigate the attitudes of elementary school principals and regular classroom teachers toward the inclusion of students with disabilities in regular classrooms. Attitudinal factors were analyzed between and within groups according to specific demographics. Three hundred forty-six subjects participated in the study. Results will be presented and discussed.

The Boys Town Longitudinal Study: Let's Don't Forget the Schools

Daniel L. Daly, David S. Shanahan and Ronald W. Thompson,
Father Flanagan's Boys Home, Boys Town, NE

Boys Town conducted a quasi-experimental longitudinal study of Boys Town residents and comparable children from 1981-1990. Education effects were measured on a variety of dimensions. Results indicate that school design may be a crucial component in children's programs. Results will be presented and discussed.

6th Annual Research Conference Agenda

Monday, March 1, 1993

5:00 PM - 6:30PM
Poster Presentations and Hospitality Hour

1 ***Network: A Community-based, Case-Conferencing Model for Cross-systems Coordination, Collaboration and Case Management***

Myra Alfreds & Carol Hardesty, Westchester County Department of Community Mental Health, White Plains, NY

2 ***Characteristics of Children and Youth At-Risk for Out-of-Community Placement***

Carla Cumblad, Kevin Quinn, Jeff Ferranti, Michael H. Epstein, *Northern Illinois University, DeKalb, IL*

3 ***An Eleven Year Retrospective: A Follow-up Study of Adolescent Girls Served in a Residential Treatment School***

LaVonne Daniels, *Crow Mountain Mental Health Consulting, Columbia, CT;* Stephen Joffe, *Concord-Assabet Adolescent Services, Concord, MA*

4 ***Establishing a Centralized Adolescent Receiving Facility in Hillsborough County, Florida***

Richard Dembo, *University of South Florida, Tampa, FL;* Richard E. Brown, *Agency for Community Treatment Services, Inc., Tampa FL*

5 ***Curriculum Development Methodology for Crisis Intervention with Children and Adolescents with Emotional Disorders or Mental Illness: A Southern Regional Perspective***

Theresa J. Early, *University of Kansas, Lawrence, KS;* Alane Winburn, *Institute for Education and Training, Oklahoma City, OK*

6 ***A Key Construct in Brief Adolescent Psychiatric Hospitalization***

Mark D. Edelstein, *UC Davis School of Medicine, Sacramento, CA*

7 ***Group Care and Therapeutic Foster Care Needs Assessment: An Overview of A State System.***

Diana J. English, & Sophia Giles, *Office of Children's Administration Research, Seattle, WA*

8 ***Decreasing Attention Deficit Hyperactivity Symptoms Utilizing an Automated Classroom Reinforcement Device***

Joseph H. Evans, University of Nebraska Medical Center, Omaha, NE

9 ***Satisfaction and Density of Support in Families with Children and Adolescents with Severe Emotional Disturbances***

Elizabeth M. Fitzgerald & Robert J. Illback, *R.E.A.C.H. of Louisville, Inc., Louisville, KY*

10 ***Reducing Out of Community Residential Programs by Improving Services to Children with Serious Emotional Disturbance and Their Families***

Wayne L. Fox & Stephen M. Broer, *University of Vermont, Burlington, VT*

11 ***Does Race/Ethnicity Influence Utilization of Emergency Mental Health Services?***

Elane Gutterman, *Rutgers University, New Brunswick, NJ;* Jeffrey S. Markowitz, *Columbia University, School of Public Health, New York, NY;* Dorothy Gaboda, *Rutgers University, New Brunswick, NJ*

12 ***Developing a Single Subject Methodology to Evaluate the Transition from Component-based Care to Individualized Care***

Susan E. Helfrich & John D. Burchard, *University of Vermont, Burlington, VT*

13 ***Measurement of Child Psychopathology and Level of Functioning in the Evaluation of a Continuum of Care Model***

V. Kay Hodges, *Eastern Michigan University, Ann Arbor, MI;* Wm. Thomas Summerfelt & Sarah Ring-Kurtz, *Vanderbilt University, Nashville, TN*

14 ***The Changing Role of Day Treatment Therapists: An Analysis of Time Utilization Data From 1986 to 1992.***

Linda C. Holcomb, *Seattle Children's Home, Seattle, WA*

15 ***Contributing to the Creation of a System of Care in Hawaii: The Perception of Front Line Service Providers***

David W. Leake, Sarah D. Burchfield & Sarah W. Bisconer, *Hawaii University, Honolulu, HI*

16 ***Mental Health Services Most Recommended for Children Leaving Community Residential Placements***

Clay Leben & Mausumi Mahua Datta Gupta, *Texas Department of Mental Health and Mental Retardation, Austin, TX*

17 ***Containing Runaway Youth In Treatment: Service Integration, Innovation, and Participatory Research***

Rosalyn Malysiak, Richard Clark & Jacqueline Graves, *Eastfield Ming Quong, Los Gatos, CA*

Monday, March 1, 1993

18 ***Parent Training: An Effective Strategy for Change in Families with Severe Behavior Disabled Preschoolers***

Billie J. Navojosky, *Positive Education Program/Early Intervention Center - West, Lakewood, OH*

19 ***Needs and Resources Assessment of Community-Based Services for Children and Youth with Emotional or Behavior Disorders***

Kevin P. Quinn, Michael H. Epstein & Carla Cumblad, *Educational Research and Services Center, DeKalb, IL*

22 ***Outcome Evaluation of Boys Town's Common Sense Parenting Program: Initial Results***

Ronald W. Thompson, Penney R. Ruma, Linda F. Schuchmann & Raymond V. Burke, *Father Flanagan's Boys' Home, Boys Town, NE*

21 ***Investigating the Validity of the Quarterly Adjustment Indicator Checklist***

James T. Yoe, *Vermont Department of Mental Health and Mental Retardation, Waterbury, VT;* Eric Bruns & Theodore A. Tighe, *University of Vermont, Burlington, VT*

Notice: ***Sign on to CFS ResourceNet***

CFS ResourceNet is an electronic Bulletin Board Service (BBS) hosted at the Florida Mental Health Institute, University of South Florida. Our goal is to exchange and provide information, share ideas, and facilitate communication between anyone interested in systems of care and policy for children and families. A computer will be available for you to sign on to ResourceNet during this poster session.

6th Annual Research Conference Agenda

Tuesday, March 2, 1993

8:00 AM - 8:45 AM
Audubon Foyer

Registration and Continental Breakfast

9:00 AM - 10:30 AM
Plenary Session

Evaluation and Research Issues surrounding Systems of Care for Children and Families

Clifford Attkisson, *University of California, San Francisco, San Francisco, CA;* Leonard Bickman, *Vanderbilt University, Nashville, TN*

This session will summarize the results of two major system of care evaluation projects. The first project is taking place in several sites in California while the second project is comparing a demonstration program in Fort Bragg, North Carolina, with two other sites.

10:45 AM - 12:15 PM
Session 13
Audubon B & C

Symposium

Project WRAP: An Interagency Collaboration Model Using a School-Based Wrap-Around Approach

Lucille M. Eber, *La Grange Area Department of Special Education, La Grange, IL*

This presentation describes the components of a school-based interagency collaboration model which emerged through an eighteen month system planning process funded by the U.S. Department of Education. Components of the system improvement model include a school inclusion process, an interagency referral and case coordination structure, development of non-categorical wrap-around supports for children and families, a local and state parent advocacy network and an interagency focus on reallocation of resources to promote wrap-around service delivery. Data from the systems needs assessment and provision of wrap-around to children and families during the planning process will also be shared.

School-Community Collaboration: A Community-Based System of Care for Children with Serious Emotional Disabilities

David Fairbanks, *SEDNET, Tallahassee, FL*

This session will describe a model demonstration project in which a coordinated system of care is being developed through multi-agency collaboration.

Tuesday, March 2, 1993

The Manatee Community Service Coordinating Council: A Collaborative Effort to Provide Services for Children With Serious Emotional Disturbance and Their Families: Process and Outcomes

Eleanor Guetzloe, *University of South Florida at St. Petersburg, St. Petersburg, FL* ; Discussant: Albert Duchnowski, *University of South Florida, Tampa, FL*

The Manatee Community Services Coordinating Council is a project funded by the Office of Special Education Programs Division of Innovation and Development for the purpose of enhancing interagency collaboration in the provision of services for children with serious emotional disturbance and their families. Phase One activity of this project, which will be completed on March 31, 1993, has focused on the development of a large community council, the mission of which has been to facilitate the delivery of recreation, community service activity, and mental health services (specific needs identified by parents, educators, and the children themselves) through the collaboration of Health and Rehabilitative Services, community mental health, schools, business and industry, community organizations, university faculty and students, and volunteers. This presentation will focus on the observable outcomes of the project, providing information about (a) social research and development as the project model, (b) the activities provided in a prior project of direct services to the target population, and (c) the qualitative research procedures used in the evaluation component.

10:45 AM - 12:15 PM
Session 14
Snowy Egret

Creating Independent Voices: The Relationship Between Family Organizations and Their Sponsoring Organizations

Harold E. Briggs *and* Nancy M. Koroloff, *Portland State University, Portland, OR* ; Sue Smith, *Georgia Parent Support Network;* Deborah Toth-Dennis, *Hawaii Families As Allies;* Lynn Holloman, *Mississippi Families As Allies;* Christina Corp, *Parents Involved Network of Pennsylvania, Inc.*

This workshop will explore the relationship between emerging family advocacy organizations and their sponsoring organizations (sometimes called fiscal agent). Content will include stages in the relationship, problems and strategies.

Parent's Perceptions of Their Child's Emotional Disturbance: A Naturalistic Study

Richard Donner, *University of Kansas, Topeka, KS*

Little is understood about families of children with emotional problems. With the movement toward intensive community based services and building collaborative relationships with families, this presentation identifies the multiple perspectives of parents regarding their child's disability. Using a naturalistic design, the results will highlight the wide range of perceptions held by parents and will provide a more clear understanding of the scope of parents' experience.

Two Models of Robert Wood Johnson Mental Health Services Program for Youth Projects Using Parents as Advocates in Pennsylvania and Wisconsin: Rationale, Strategies and Outcomes

Maggie Mezera, *Wisconsin Family Ties, Inc., Madison, WI;* Christina Corp, *Parents Involved Network, Folsom, PA*

Parent advocates in Pennsylvania and Wisconsin provide services to families that are recognized as valuable and necessary components of the array of services made available at these two sites of this national demonstration program. This example of family collaboration has great potential in the effort to improve mental health services to children and their families.

10:45 AM - 12:15 PM
Session 15
Sand Hill Crane

Child Guidance Clinic Drop Outs: Clinical and Socio-Demographic Factors

Paula Armbruster and Theodore Fallon, *Yale University, New Haven, CT*

This study compares the socio-demographic and clinical characteristics of patients who drop out and those who continue at a child guidance clinic. A sample of applicants to the clinic (N=304) was followed for one year. Clinical and socio-demographic factors associated with dropout were identified at four points in the clinical process: intake, during evaluation, evaluation completed, and treatment. Results will be presented and discussed.

Children who Sexually Abuse Other Children: Research Findings from Three Studies

Diana J. English, *Office of Children's Administration Research, Seattle, WA*

Recent research in Washington State identified 650 children on public agency child welfare caseloads who had committed serious sexually aggressive acts and documented incidents of sexual aggression. The paper will present information on the characteristics of the youth, comparing sexually aggressive youth under age 12 to children over the age of 12. Characteristics of the youths, including age, gender, developmental status, and behaviors, characteristics and families will be presented. Risk factors for re-offense and outcomes will also be explored. The paper will conclude with a discussion of the policy and program implications for these children based on study findings.

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Tuesday, March 2, 1993

Measurement of Child Psychopathology and Level of Functioning in the Evaluation of a Continuum of Care Model

V. Kay Hodges, *Eastern Michigan University, Ann Arbor, MI;* Wm. Thomas Summerfelt, and Sarah Ring-Kurtz, *Vanderbilt University, Nashville, TN*

The Ft. Bragg Evaluation Project is the first comprehensive evaluation of a system of care that includes the assessment of mental health outcomes. The instrument package used in the outcome study includes a semi-standardized diagnostic interview for children and adolescents (Child Assessment Schedule) and a multi-dimensional level of functioning instrument (child and Adolescent Functioning Assessment Scale). The Utility and performance of these two measures for assessing mental health outcomes will be discussed.

10:45 AM - 12:15 PM
Session 16
Wilson's Plover

Qualitative Evaluation of Community Based Prevention Services: The Monmouth County 65K Program

Carol J. Williams, *New Jersey Division of Youth and Family Services, Trenton, NJ;* Ann Gans, *Mental Health Association of Monmouth County, Red Bank, NJ*

This paper will explore the use of qualitative research techniques in evaluating the 65K Program, a prevention program developed to strengthen community based support systems for families who have a child at risk of residential placement, with the objective of preventing such a placement.

A System of Care for At-Risk Infants and Their Families

Jean W. Gowen, *Morganton, NC*

The efficacy of community-level and family-level interventions to promote the mental health of infants who are at-risk are being assessed in a research and demonstration project. The three main purposes of the community-level intervention were to: (a) increase the number of appropriate referrals of infants to the family-based intervention program, (b) educate a broad range of community service providers regarding infant mental health, and (c) strengthen the network of community people who work with high risk families with infants. Data will be provided regarding the effects of the intervention on types of referrals and community networking.

Comprehensive Services to Families as a Means for Prevention

Sebastian Striefel, *Utah State University, Logan, UT*

The Community-Family Partnership Project is one of 32 service demonstration projects funded by the Administration for Children and Families. The Community-Family Partnership Project is in its fourth year of operation. The major goals of the project are to break the cycle of poverty and its impact by working in partnership with families to assist them in maximizing the development of each child under age five, to prevent abuse, neglect, school drop out and mental health problems; and to help the family achieve economic self-sufficiency. A progress report and service description will be provided.

1:45 PM - 3:15 PM
Session 17
Audubon B & C

Symposium

Systems of Care Research in California: Current Results and Future Directions

Abram B. Rosenblatt, C. Clifford Attkisson, Lori Smith, June Madsen, Stanley L. Hughes and Karyn Dresser, *University of California-San Francisco, San Francisco*, CA

This symposium presents findings from a unique program of evaluation and services research studying systems of care for youth suffering from severe emotional disorder in California. Three interwoven multi-site research projects designed to study and evaluate the effects of innovative integrated services systems are now yielding a first wave of results. One set of service system interventions being studied are replications in three California counties of a model care system pioneered in Ventura County, California. A related, but separate innovative care system also under study is being implemented in San Francisco. Data on the background, clinical epidemiology, and functional status of the youth served and on expenditures and placements for restrictive levels of care will be reported. Additionally, results from related inchoate research projects on California state hospital facilities and youth receiving care in San Francisco will be presented.

1:45 PM - 3:15 PM
Session 18
Snowy Egret

A University-Based Multi-Disciplinary Training Program: State-of-the-Art Preparation for Professionals to Work with Children and Their Families

Mike Johnson, *University of South Florida, Tampa, FL*

This session will describe a University-based training program for pre-doctoral students who wish to work with children and their families in public sector programs. Student trainees are in several different departments in the University, including clinical psychology, social work, school psychology, and nursing. A program description and some student learning outcomes will be presented.

Staffing Systems of Care for Children and Families: Workforce Issues Related to Community Based Service Delivery for Children and Adolescents with Serious Emotional Disturbances and Their Families

Sheila A. Pires, *Human Service Collaborative, Washington, DC;* Ann Patterson, *Division of Mental Health Service, Little Rock, AR*; Ellen B. Kagen, *Mental Health Services for Youth, Washington, DC*

This presentation describes the results of a regional needs assessment of workforce issues related to implementing systems of care for children with serious emotional disturbance and their families. Results are based on a survey of key stakeholders in the region, including state mental health officials, local providers, advocates and others. The survey sought to identify the priorities of public child mental health systems over the next five years, the implications of health systems over the next five years and the implications these future directions for the children's workforce. The surveys addressed issues related to recruitment and retention, staff distribution and utilization, staffing requirements for community based services, preservice and inservice training, state capacity to address workforce issues and state university linkages.

Curriculum Development for Children's Case Managers: Results of a Southern Human Resource Development (HRD) Regional Survey

Norma R. Raiff, *University of Pittsburgh, Pittsburgh, PA;* Mardi A. Carter, *Department of Mental Health, Jackson, MS;* Barbara Grunow, *Department of Mental Health/Mental Retardation, Nashville, TN*

This session will discuss the development and implementation of a twelve-state key informant telephone survey intended to identify priority areas for training children's case managers and their supervisors. A snowball technique was used to identify key informants knowledgeable about state policy, programming, and current and anticipated personnel profiles. Respondents included state and regional level administrators, program and training directors, supervisors, trainers and advocates. This symposium will discuss philosophic and implementation issues in conducting research within this collaborative context. The results of the survey and a comparison with a parallel study in adult case management will be detailed.

1:45 PM - 3:15 PM
Session 19
Sand Hill Crane

Transition of Youth and Young Adults with Emotional/ Behavioral Disorders into Employment, Educational Opportunities, and Independent Living

Hewitt B. Clark and Elizabeth S. Stewart, *University of South Florida, Tampa, FL*

The purpose of the current study was to identify the values and best pictures of programs which are preparing and supporting youth and young adults with emotional/behavioral disorders, in the transition from school-age into employment, educational opportunities, and independent living. This study was conducted by initially surveying 254 program nominees in order to identify programs that were eligible for site visits. Based on the survey and site visit information, recommendations were formulated as to (a) program values that appear to be important in guiding transition programs, and (b) types of support, services, and best practices that may need to be available to facilitate successful transitioning for these individuals.

Transition of Emotional and Behavioral Disordered Youth to Adult Roles and Services

Karen V. Unger, *Boston University, Boston, MA;* Starr Silver, *University of South Florida, Tampa, FL*

This symposium will discuss factors associated with a successful transition for emotional and behavioral disordered youths, age 18-22, from school to work and from family living to independent living. Utilizing an existing longitudinal study being conducted by the Center for Children's Mental

Health, "The National Adolescent and Child Treatment Survey" (NACTS)(N=812), a subset of youth and their parents (N=224) were interviewed to determine the facilitators and barriers to a successful transition. Four domains were examined: living, learning, working, and social. This presentation will describe the characteristics of the young adults and the services they received that relate to making a successful transition. The barriers to transition will also be described as identified by the youth and their parents. Programmatic and policy implications will be discussed.

1:45 PM - 3:15 PM
Session 20
Wilson's Plover

The Kentucky IMPACT Program at Year Two: Descriptive and Inferential Analysis

Robert J. Illback, *Kentucky Department of Mental Health, Louisville, KY;* Elizabeth Fitzgerald, *R.E.A.C.H. of Louisville, Inc., Louisville, KY;* James Call, *Kentucky Department of Mental Health, Frankfort, KY*

The Kentucky IMPACT program has completed its second year of operation. This presentation will focus on data available on approximately 850 youngsters served during this period. An information system includes data for the following variables: demographics and risk factors, restrictiveness and placement stability, density and perceived helpfulness of social support to families, child behavior and social competence, service delivery configurations, and reasons for exit. The analysis focuses on descriptive summaries of data available on these dimensions as well as inferential analysis of pre- and post-intervention and data subsets using multiple analysis of covariance, discriminant function analysis, and cluster analysis techniques. Particular emphasis will be placed on meaningful sub-groupings within the clinical population and with regard to service delivery configurations.

The Role of Youth Satisfaction Surveys in Evaluating Outcomes for Children and Adolescents Receiving Community-Based, Wraparound Services

John D. Burchard, Lee Rosen and Michelle Gendebien, *University of Vermont, Burlington, VT*

In the assessment of outcomes for children and adolescents experiencing severe emotional and behavioral problems, it seems that the kids themselves are seldom asked for their opinions. We have begun to systematically question children and adolescents experiencing emotional and behavioral problems about their satisfaction with, and sense of involvement in, their services. This paper will present youth-satisfaction data, spanning a three month period, on twenty children and adolescents living in Vermont, many of whom have been receiving intensive, community-based, wraparound services. In addition to presenting data on general satisfaction with services, we will attempt to show why some kids might be more satisfied than others. It is hoped that such information will shed light on kids' feeling about their services and the impact of their feelings on the efficacy of those services.

Tuesday, March 2, 1993

Assessing the Client Satisfaction and Client Utilization of Services in a Continuum of Care Model

Ana Maria Brannan and John Tichenor, *Vanderbilt University, Nashville, TN*

As part of a comprehensive evaluation of an innovative continuum of care demonstration the satisfaction scales were developed. In this paper, the validity and internal consistency of these scales will be presented. In addition, the measurement of client services utilization using multiple data bases, including claims data, program management information systems and parents' reports of utilization will be discussed. Also, the level of agreement between the parents reports of Utilization ant the providers databases is examined.

3:15 PM - 3:00PM ***Break***

3:30 PM - 5:00 PM

Session 21 Symposium

Audubon B & C ***Patterns of Children's Mental Health Status and Service Utilization: Preliminary Findings From the Fort Bragg Evaluation Project***

Carolyn Breda, Ken Davis, Craig Anne Heflinger, Ana Maria Brannan, Bahr Weiss, Warren Lambert, and Leonard Bickman, *Vanderbilt University, Nashville, TN;* V. Kay Hodges, *Eastern Michigan University, Ann Arbor, MI*

This symposium explores the relationships between the mental health status of children, their utilization of various types of services, and their subsequent changes in mental health outcomes. Fort Bragg Evaluation Project data on 396 child and adolescent clients and their families are presented for two time periods: entry into mental health services and approximately six months later. Pre- and post-intervention measures of the child's psychopathology, social competence, and family functioning are presented, as well as the child's and parent's level of satisfaction with services received. Service utilization data provide indicators of the types and intensity of services these children received and are linked through regression modeling to mental health outcomes. A taxonomy based on symptom change is presented and factors that mediate the relationship between mental health status and service utilization are also discussed. These are preliminary findings and will not include cross-site comparisons.

3:30 PM - 5:00 PM
Session 22
Snowy Egret

Using Aggregated Progress Indicators to Evaluate Children's Progress in Treatment Foster Care: Replication of a Statewide Study

Ann Vander Stoep, Bart Taylor and Linda Holcomb, *Seattle Children's Home, Seattle, WA*

Progress Indicator Tracking has been used to measure the course of treatment in several statewide children's mental health services evaluations. In the State of Washington all children in the Children's Hospital Alternative Program, a treatment foster care program, are tracked daily by their foster parents on seven progress indicators. This paper presents the results of testing the hypotheses that: 1) children will exhibit an increasing rate of problem behaviors over the first four or five months in treatment foster care, 2) behaviors will decrease during the next six month period, reaching a rate of occurrence at 10 months which is lower than in the initial months, and 3) patterns of progress will vary by gender, age and diagnosis.

Family Reconciliation Services: Over a Decade Later

Diana J. English, Sophia Giles, and Susan Welch, *Office of Children's Administration Research, Seattle, WA*

Nationally, Washington State's 1977 "Family Conflict" law (RCW 14.32A) has been recognized as visionary legislation. That is where the "Homebuilders" model found its genesis. Over a decade later, a comprehensive study reviews the two phases of service delivery, where family-centered, in-home crisis intervention is offered to the family of the status offender, instead of responding to the youth as a juvenile offender. Phase I consists of the intake component and up to 4 hours of social work intervention, including information and referral. Phase II involves more extensive counseling service, that are available for the next 30 days following intake. The counseling services are characterized by flexibility of hours, location of delivery, and are focused on problem solving, improving communication and parenting skills.

Results of a North American Survey of Treatment Foster Care Programs

Joe Hudson, *The University of Calgary (Edmonton Division), Edmonton, Alberta, Canada;* Burt Galaway, *University of Manitoba, Winnipeg, Manitoba, Canada;* Richard W. Nutter, *The University of Calgary (Edmonton Division), Edmonton, Canada*

This session presents detailed information compiled from a recently completed (1992) survey of 321 treatment foster care programs currently operating throughout the United States and Canada. Particular attention is given to the diversity of the 321 programs and the manner in which they fit within a system of services for youth. Survey variables on which information will be presented include administrative auspices of the programs, program size, referral source, number and characteristics of youth served, treatment modalities employed, payment schedules and amounts, service activities carried out, pre-service and in-service training requirements, contracting procedures, caseload sized, and the use of support groups.

Tuesday, March 2, 1993

3:30 PM - 5:00 PM
Session 23
Sand Hill Crane

Continuous Quality and Cost Improvement in Child and Youth Care and Treatment: Three Methods of "Research and Development" for Behavioral Health Service Systems

Robert P. Hawkins, *West Virginia University, Morgantown, WV*

It is proposed that every child serving agency conduct some level of research and development (R&D) as a method of improving the quality and/or cost of its own services, and that larger and more financially independent agencies conduct enough R&D to contribute to improving the quality and cost of the whole field's services. What is required for such continuous quality and cost improvement (CQCI) is ongoing cycling between innovation and evaluation; neither is enough by itself. Three R&D strategies for CQCI in child/youth behavioral health systems will be presented, each with its own advantages and limitations. If we fail to conduct such R&D we will be limited in our effectiveness with youths having severe disturbance and our ability to justify costs to legislators, other policy makers, and the public.

Children and Mental Disorder in California: A Preliminary Results of the Statewide Mental Health Needs Assessment Project

Amando Cablas and Jeanette Jerrell, *Santa Clara County Mental Health Services Research Center, San Jose, CA*

This paper presents an overview of the preliminary data on children from the California Mental Health Needs Assessment Project. The study was conducted to determine the prevalence of serious mental disorders among adults and children throughout the state. A total of 9,100 households were interviewed. For children, a multi-method approach consisting of a telephone interview and a rating scale, the Child Behavior Checklist (CBCL) was used. A subsample of households with a child who screened positive during the telephone interview for mental illness was asked to complete the CBCL. Children were identified as severely mentally ill if they: 1) had persistent psychosocial problems for 1 year or more, and 2) met at least 2 additional criteria used by the state to define serious mental illness in children. Findings will be presented for the number of positive scores for children on each of these criteria, as well as the major findings for the CBCLs returned.

Measuring Empowerment in Families Whose Children Have Emotional Disabilities: A Brief Questionnaire

Paul E. Koren and Neil DeChillo, *Portland State University, Portland, OR*

This paper described the development and empirical examination of a brief questionnaire for assessing empowerment in families whose children have emotional disabilities. The questionnaire is based on a two-dimensional conceptual framework of empowerment derived from the literature. One dimension reflects empowerment with respect to the family, service system, and larger community and political environment. The other dimension reflects the expression of empowerment as attitudes, knowledge, and behaviors. The paper outlines the questionnaire's conceptual basis, describes its development, and presents analyses of reliability and validity based on 440 responses of family members. Applications of the instrument in both research and service delivery are discussed.

3:30 PM - 5:00 PM

Session 24 Symposium

Wilson's Plover ***School-Based Mental Health Services and Service System Research: Critical Issues in Design, Measurement and Implementation***

Kimberly Hoagwood, *National Institute of Mental Health, Rockville, MD;* Martha Coutinho, *Department of Education, Washington, DC;* Cynthia Carlson, *University of Texas, Austin, TX;* Lavome Robinson, *DePaul University, Chicago, IL;* Gregory Clarke, *Oregon Health Sciences University, Portland, OR;* Cliff Attkisson, *University of California -San Francisco, San Francisco, CA;* Discussant: Steve Forness, *University of California-Los Angeles, Los Angeles, CA*

This Symposium will convene investigators who are conducting state-of-the-art research on mental health services to children and adolescents in school settings or research on the systemic juncture between education and mental health systems. The purpose of the symposium is to identify critical issues in designing studies in school settings, in modeling service system integration efforts, in selecting appropriate measures of both educational and mental health outcomes, in monitoring fidelity to interventions in addressing issues of confidentiality and consent, and in data analytic approaches.

The presenters, all of whom are actively engaged in research on this critical juncture between education and mental health, will identify methodological challenges in conducting their research, as well as creative approaches to these challenges. The ultimate goal of the Symposium is to foster innovative research strategies, approaches, and analyses so that important service research questions can be investigated and answered.

Tuesday, March 2, 1993

5:00 PM - 6:30PM
Poster Presentations and Hospitality Hour

1 ***A Residential Treatment Program for Substance Abusing Women and Their Children: An Integrative Model***

Ann Albrecht Reyes, *Bethesda Hospitals, Cincinnati, OH;* Jose Reyes, *St. Elizabeth Medical Center, Covington, KY*

2 ***A Quality Assessment Tool for Mental Health Services Case Management***

Deborah M. Bryant, *Vanderbilt Institute for Public Policy Studies, Nashville, TN*

3 ***Changes in Family Functioning and Child Behavior Problems After Outpatient Mental Health Treatment***

Rosalyn A. Chrenka, J. Clifford Kaspar & Laura Raska, *Loyola University Doyle Center, Chicago, IL*

4 ***The Role of Professionals in Promoting Parents' Perceptions of Positive Contributions of Their Children with Emotional Disorders***

Theresa J. Early, *The University of Kansas, Lawrence, KS*

5 ***Police in the Schools: The Effect on the System – A Program Evaluation***

Ellen Goggins, *Akron Public Schools, Akron, OH;* Isadore Newman, *North Eastern Ohio College of Medicine, University of Akron, Akron, OH;* Donna Waechter & Brian Williams, *Akron Public Schools, Akron , OH*

6 ***Reasons for Termination of Mental Health Treatment Among Children and Adolescents***

Lisa Grupe & Olivia Underwood, *Vanderbilt University Fort Campbell Site, Nashville, TN*

7 ***The Relationship Between Race And Children's Mental Health Status***

Tonia Lee Hardyway, *Vanderbilt University, Nashville, TN*

8 ***Identifying Students Needing Mental Health Services: Comparing Teacher Referral to School-wide Assessments***

Vicki Harris, Bahr Weiss & Thomas Catron, *Vanderbilt University, Nashville, TN*

9 ***The South Carolina Continuum of Care (A Decade of Service)***

Kerry T. Hinkle, Isaac Joyner & Wendell Price, *South Carolina Continuum of Care, Columbia, SC*

10 ***Assessing Client Satisfaction and Client Utilization of Services in a Continuum of Care Model***

Ana Maria Brannan & John Tichenor, *Vanderbilt University, Nashville, TN*

11 ***Preservice Training Deficits in Classroom Behavioral Management: Can School Districts Ever Recover?***

Morgan P. Kelly, Daniel G. Weidner, Ted Esser, Kristi K. Noteboom, *Eastern Nebraska Community Office of Mental Health, Omaha, NE;*

12 ***10 KIDS: K.I.D.S.: An Interprofessional Managed Care Approach to Returning Youth with SED Placed Out-of-County Using Non-Traditional Cross-System Collaborative Strategies***

Douglas McCoard, *Huckleberry House, Inc., Columbus, OH;* Betsy Cauble & Jack Donahue, *Franklin County Children Services, Grove City, OH;* Neil Brown, *Huckleberry House, Inc., Columbus OH;* Robin Gilbert, *Kids In Different Systems (K.I.D.S), Grove City, Ohio;* Rob Marx, *Star Commonwealth/Hannah Neil Center for Children, Columbus, OH;* Patricia Miles, *Pressley Ridge Center for Research and Public Policy, Dublin, OH;* Beth Ullery, *Franklin County Alcohol, Drug Addiction & Mental Health Board, Columbus, OH*

13 ***The Journey Toward Independence: Transitional Services for Adolescents***

Janice M Moore, Joan M Hadley, Kathy Daws-Lawrence & Shelly Morningstar, *Transitional Residency Independence Services, Stratford , NJ*

14 ***Substance Use/Abuse Patterns of Youth With Mental Illness In Compared With Patterns from Other Disability Groups***

Dennis Moore, *Wright State University, Dayton, OH*

15 ***Family Functioning and Family Stressors: Agreement between Reports by Adolescents and their Parents***

Denine A. Northrup, *Vanderbilt University, Nashville, TN*

16 ***Evaluating Mental Health Services in Regular Education***

William E. Reay, *Eastern Nebraska Community Office of Mental Health, Omaha, NE;* Pallavi Chavda, *Bellevue College, Bellevue, NE*

17 ***Developing a Training Program for Interviewers Administering Diagnostic Instruments for Outcome Studies***

Sarah Ring-Kurtz, *Vanderbilt University, Nashville, TN;* Kay Hodges *Eastern Michigan University, Ann Arbor, MI*

Tuesday, March 2, 1993

18 ***Parent Involvement in Children's Mental Health Services: The Relationships Between Family Factors and Parent Involvement***

Susan E. Sonnichsen, *Vanderbilt University, Nashville, TN*

19 ***Service Use and Maternal Well-Being in a Child Abuse Prevention Program***

Zvi Strassberg & Robert M. Brayden, *Vanderbilt University, Nashville, TN*

20 ***A Training Model To Support Educators For Full Inclusion Of Students With Serious Emotional Disturbance In General Education Classrooms***

Ruth Walker Hamilton, *Center for Developmental Disabilities*
The University Affiliated Program of Vermont, Burlington, VT

Notice: ***Sign on to CFS ResourceNet***

CFS ResourceNet is an electronic Bulletin Board Service (BBS) hosted at the Florida at the Florida Mental Health Institute, University of South Florida. Our goal is to exchange and provide information, share ideas and facilitate communication between anyone interested in systems of care and policy for children and families. A computer will be available for you to sign on to ResourceNet during this poster session.

Wednesday, March 3, 1993

9:00 AM - 10:30 AM
Session 25
Audubon B & C

Symposium

Community-Based Alternatives to Residential Treatment: Description of Some Current Service Delivery Models and Some Initial Outcome Findings

Mike Johnson and Kim Hall, University *of South Florida, Tampa, FL;* Karl Dennis, *Kaleidoscope, Chicago, IL ;* Mario Hernandez, University *of South Florida;* John VanDenBerg, *Center for Research and Public Policy, Pittsburg, PA; Discussant:* John Burchard, *University of Vermont, Burlington, VT*

This Symposium will examine some of the major program models that are currently operating as alternatives to traditional residential treatment. Models range from the Kaleidoscope "Wrap-Around" model to the Ventura County Integrated System. Initial findings will be presented from a follow-up outcome study of these programs.

9:00 AM - 10:30 AM
Session 26
Snowy Egret

Symposium

An Individualized System of Care for Foster Children with Behavioral and Emotional Disorders: Early Results

Hewitt B. Clark, L. Adlai Boyd, Barbara Lee, Elizabeth S. Stewart and Carol Anne Redditt, *University of South Florida, Tampa, FL*

The purpose of this study is twofold: 1) to establish an individualized system of care for providing mental health and related services (through an Individualized Support Team) to foster children, ages 7-15 years, who are at risk of severe emotional/behavioral disturbance; and 2) to conduct a controlled study of the relative efficacy and effectiveness of two treatment systems (i. e., Individualized Support Team and Standard Foster Care Practice) in improving permanency planning, preventing regressive placements, and improving emotional and behavioral adjustment, school attendance, and academic performance of the children.

Preliminary Outcomes of Two Intensive Community-Based Service Programs for Children with Serious Emotional Disturbance

Mary E. Evans, Mary I. Armstrong, Steven Huz and Norin Dollard, *New York State Office of Mental Health, Albany, NY*

The New York State Office of Mental Health is conducting a research demonstration project (R18) to assess the comparative effectiveness of therapeutic foster care and intensive supportive care within the natural home environment. This paper overviews the program models and discusses the characteristics and functioning of study participants on enrollment and at 6 month follow-up. Data on services provided and use of flexible service dollars are also presented.

Wednesday, March 3, 1993

West Virginia R18 Grant

Deborah Rugs, *University of South Florida, Tampa, FL;* Vera Warner, and Andrew Johnson, *Department. of Health and Human Resources, Charleston, WV;* Gayle Freedman, *University of South Florida, Tampa, FL*

The West Virginia research project is an investigation of three service delivery systems for children with needs for mental health services. This presentation will cover the first year results on restrictiveness of living environment, cost to the state, and contacts with juvenile justice. Preliminary results of the family portion of the study will also be covered, parent reported CBCL scores, Family Assessment Scores, and Parent Satisfaction with Services.

9:00 AM - 10:30 AM
Session 27
Sand Hill Crane

Using Survival Analysis to Evaluate Case Management with Children

John Poertner, *University of Kansas, Lawrence, KS*

One important measure of program success is outcome for consumers. This paper discusses survival analysis as a way to evaluate case management with children by studying the length of time to changes in living status (moves to more/less restrictive settings).

Case Management Services for Children and Adolescents with Severe Emotional Disturbance: A Statewide Analysis of Service Utilization Patterns and Outcomes

Randall L. Lemoine, Tony Speier, Sally Ellzey, Paul Balson, Tom Dumas and Walter W. Shervington, *Louisiana Office of Mental Health, Baton Rouge, LA*

The present study provides an analysis of service utilization patterns and outcomes from two years of longitudinal data. Case management services provided to children and adolescents with severe emotional disturbance are compared and contrasted to services for adults with SMI who were served at the same time and in the same case management units, but by adult-oriented case managers. The study illustrates the unique focus, intensity, length, and participants in case management services to children and adolescents. Outcomes of services are illustrated in terms of service goals met, the length of psychiatric hospitalizations and out-of-home placements as compared to the baseline year preceding case management, and service-related changes in housing arrangements and educational status.

Peeking Inside the Black Box of Case Management/Service Coordination for Children and Youth with SED: Findings From An Evaluation of Mecklenburg County, NC: Local CASSP Program.

Deborah Franks Jacobs, *Shippensburg University, Shippensburg, PA;* Anda Cochran and Pam Jackson, *Mecklenburg County Mental Health, Charlotte, NC*

This paper presents the results of an evaluation of a three year local CASSP grant which initiated case management/service coordination in the area of Charlotte, N C. The evaluation design triangulated data from interviews with key stakeholders in the child serving system, satisfaction surveys for youth and families, and a pre-post test client outcomes component on thirty-six children and youth. In an attempt to pry open the "Black Box" which has been called case management/service coordination, functions performed by the staff were recorded in quarter hour intervals for a six month period for twenty-five clients. This paper reports on the positive finding of this evaluation; addresses community entry issues when initiating services of this type; and discusses the relationship between the type of activities staff perform and the outcomes for clients.

9:00 AM - 10:30 AM
Session 28
Wilson's Plover

Psychiatric Hospitalization of Foster Children: The Current and Future Use of Medicaid

Robert M. Goerge and Ruth Osuch, *University of Chicago, Chicago, IL*

This paper will present findings of a study on the use of both Medicaid-reimbursed and state-operated psychiatric hospitalization by foster children in Illinois over a two-year period. The progression of services both before and after hospitalization and the circumstances around hospitalization is analyzed in order to determine what leads to being hospitalized. The analysis uses a unique source of data, the Integrated Database on Children's Services in Illinois, which combines the information from all the state agencies responsible for human service in Illinois. Data that is included goes back to 1980 and is linked by individual child to create the human service career of the child. Descriptive results are presented and event-history analysis are used to develop the multivariate model of psychiatric hospitalizations and the transitions made before and after those episodes.

Does Program Auspice Impact on the Delivery of Services to Emotionally Disturbed Children: A Study of Residential Treatment Programs (and their Delivery Systems) in Florida

Barbara A. Spencer, *Florida State University, Tallahassee, FL*

While there is some empirical evidence which suggests differences between the relative effectiveness of not-for-profit and for-profit adult care providers, little research had been conducted concerning the impact of auspice on either a) child care provider effectiveness, or b) the ability of delivery systems to provide services to children. This study investigates the impact of program auspice on the ability of all of the programs within a delivery system to provide services to children with emotional disturbance who have been placed into residential treatment centers.

Wednesday, March 3, 1993

Short Term Family-Based Residential Treatment as an Alternative to Psychiatric Hospitalization for Children

Edwin J. Mikkelsen, *Massachusetts Mental Health Center, Harvard Medical School, MA;* Gerald M. Bereika and Julie C. McKenzie, *Mentor Clinical Care, Boston, MA* ; Paper Presented by Donald Monack, *Mentor Clinical Care, Boston, MA*

This study reports the results obtained with a short term residential treatment model specifically designed to be an alternative to psychiatric hospitalization for children and adolescents. Average length of stay in the program was 16.8 days. Admissions and discharge data is reported for 112 consecutive admissions to the program as well as three-month follow-up for 61 individuals. The results are compared to studies involving inpatient psychiatric hospitalization of children. The comparison indicates that there is considerable overlap between the diagnostic groups treated in this program as compared to those admitted to psychiatric hospitals. Outcome and follow-up data will be presented and discussed.

10:45 AM - 12:15 PM
Session 29 Symposium
Audubon B & C

Family Preservation Using Multisystemic Treatment with Adolescent Offenders and Substance Abusers: Long-Term Outcome, Current Projects, and Interagency Collaboration

Scott W. Henggeler, *University of South Carolina, Charleston, SC;* Sonja K. Schoenwald, *Medical University of South Carolina, Charleston, SC;* Charles M. Borduin, *University of Missouri-Columbia, Columbia, MO;* Susan Pickrel and Melisa Rowland, *Medical University of South Carolina, Charleston, SC;* Michael J. Brondino, *South Carolina Department of Mental Health, Columbia, SC;* David G. Scherer, *University of South Carolina, Columbia, SC*

The purpose of this symposium is to present findings, updates, and pertinent issues regarding several controlled clinical trials evaluating the effectiveness of family preservation using multisystemic treatment with adolescent substance abuse and serious criminal behavior. The first presentation describes key aspects of multisystemic treatment as used within the family preservation model of service delivery. Second, two year follow up data from the highly successful Greenville Family Preservation Project will be presented. The third presentation examines findings from the Missouri Delinquency Project, which represents the most comprehensive and extensive evaluation of MST to date. The fourth presentation describes progress in a NIDA-funded project evaluating the effectiveness of multisystemic family preservation services with substance abusing delinquents. The fifth presentation provides preliminary results regarding a NIMH-funded evaluation of the diffusion of family preservation using multisystemic therapy with serious juvenile offenders in rural sites. Finally, key issues in the development of interagency collaboration are discussed, as such collaboration is essential to the success of family preservation projects.

10:45 AM - 12:15 PM
Session 30
Snowy Egret

Symposium

Recent Findings From the National Adolescent and Child Treatment Study (NACTS): A Longitudinal Study of Youth with Severe E motional Disturbances

Al Duchnowski, Paul Greenbaum, Krista Kutash, Sharon Lardieri and Mark Prange, *University of South Florida, Tampa, FL*

NACTS is a comprehensive longitudinal study designed to describe the characteristics, functional levels, receipt of services, and outcomes among a large, six-state sample of children and adolescents with serious emotional disturbances (N=812). Today's symposium will focus on results from the initial 4 waves of data collection. Specific topics discussed will include multi-source assessment of children's behavior problems, persistence of conduct disorder, parents' recommendations for improved service, and assessment of children's social skills.

10:45 AM - 12:15 PM
Session 31
Sand Hill Crane

A Comparison of Children's In-home Psychiatric Emergency Services: Service Design and Research Plan

Mary I. Armstrong and Mary E. Evans, *New York State Office of Mental Health, Albany, NY*

New York State currently offers one in-home children's psychiatric emergency service which is based on the Homebuilders mode. The aims of the research demonstration are to establish two new in-home emergency programs and to compare the outcomes of these programs when all three programs exist in the same urban community. The evaluation will also determine which children and families experience the best outcomes with which model. The Hispanic Research Center at Fordham University is a key collaborator in this research.

Organizing for Systems Change: Michigan's CASSP Initiative, It's Successes and It's Challenges

Patterson A . Terry, *Michigan State University, East Lansing, MI;* James R. Wotring, *Michigan Department of Mental Health, Lansing, MI*

Michigan's CASSP Initiative began in 1990 as a small project with modest goals. There has been a decrease in the federal dollars allotted, and practically no state funding support has been available beyond the contribution of employee time for coordination efforts. Yet the initiative has developed involvement by the directors of the State human services agencies, it has leveraged other grant monies for complementary efforts, it has attracted the interest of county human service agency directors all over the state, and it stands a good chance of catalyzing statewide changes in service to children and youth with emotional disturbances, and their families The unexpected, remarkable success of the program suggests that organizing for system wide change involves principles different from those normally applied to constructing an exemplary demonstration project.

Wednesday, March 3, 1993

Predicting Systems of Care for Seriously Mentally Ill Adolescents: An Analysis of National Data

Kathleen Pottick, Stephen Hansell, Elane Gutterman and Helene White, *Rutgers University, New Brunswick, NJ*

Little is known about the factors that may systematically and differentially predict hospitalization or other types of mental health services, such as outpatient or partial care services. This study uses 1986 nationally representative data collected by the National Institute of Mental Health to describe the distribution of services provided to adolescents in psychiatric inpatient, outpatient, and partial care facilities, and it tests multiple variable models to determine factors which predict the selection of adolescents into different service streams. Implications of the results for the design, delivery, and evaluation of mental health services for adolescents are discussed.

10:45 AM - 12:15 PM
Session 32
Wilson's Plover

Preliminary Findings From Program Evaluation Research on the North Idaho Child and Adolescent Service System Project

Bill Horner and JoAnn Ray, *Eastern Washington University, Cheney, WA*

Preliminary findings from exploratory data analysis of program evaluation research on the North Idaho CASSP Project. Findings will be presented on aspects of three domains of concerns in providing services to children with severe emotional disturbance and their families: child and family psychosocial functioning and parent satisfaction with service provision. For a variety of reasons, this report should be understood as exploratory rather than confirmatory in nature

North Idaho Rural System of Care: The First 50 Families

Jody Lubrecht, *Idaho Family and Children's Services, Coeur d'Alene, ID*

The presentation will focus on the first 50 client families provided with intensive family, school and community-based (demonstration) services or intensive residential, institutional or hospital (comparison) services under the auspices of the North Idaho Rural System of Care Research Demonstration Project. Material to be covered will include information on intensive services development, evolution and implementation; wraparound services funding and tracking; demographic and historical data; early outcome indicators; and early family satisfaction returns.

Wednesday, March 3, 1993

Measuring the Implementation of CASSP Principles in Children's Mental Health Programs

Robert I. Paulson, Neal DeChillo, Paul Koren, Denise Stuntzner-Gibson and Barbara Friesen, *Portland State University, Portland, OR*

This paper presents the initial efforts to measure the implementation of CASSP principles through the use of a "Service Fit" Questionnaire and refined a "Family Empowerment Scale" developed as part of a R18 research demonstration evaluation of the Oregon Partners' Project, one of the Robert Wood Johnson Foundation's demonstration projects. Specific components of the instruments measure whether services, are comprehensive, coordinated, individualized, family centered, protective of children's rights, culturally appropriate and where appropriate address the transition needs of adolescents approaching adulthood. The conceptual foundation for the research instruments, their psychometric properties, their relationship with each of the CASSP Principles, and the preliminary results from these measures will be presented.

12:15 PM
Plenary Session and Luncheon

Children's Mental Health Research: Exploring the Participatory Approach.

Robert M. Friedman, *University of South Florida, Tampa, FL*

This presentation will examine the use of children and adolescents as sources of information in system of care research. Different measurement strategies for securing information from children and adolescents will be presented, and the advantages and limitations of using the strategies will be discussed.

Evaluation of Systems of Care

Chapter 1

Patterns of Service Utilization and Mental Health Status: Preliminary Findings from the Fort Bragg Evaluation Project

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This research is based on data collected through the Fort Bragg Evaluation Project for 396 children and adolescents receiving formal mental health services. Information on the mental health status of the youths as well as relevant family measures was obtained at the time of intake. Utilization data were based on all known services received in the subsequent six months. Cluster analysis was used to categorize the sample into meaningful service types based on the various services each youth received. Discriminant analysis was then used to identify those mental health and family measures that best predicted service type. In general, the expected relationship between pattern of use and mental health and family measures was confirmed; youths with more serious problems received a greater array and more intensive types of treatment than those with less serious problems. This finding provides evidence for the validity of empirically-derived service typologies.

Introduction

Many suggest that a greater array of services can better meet the diverse needs of children and adolescents (Saxe, Cross, & Silverman, 1989; Stroul & Friedman, 1986). Most would agree that there should be some relationship between the mental health status of youths and the services they receive. Unfortunately, existing research is not clear on what is meant by services nor on what the theoretical relationship is between need and service use. Indeed, in their study of a treatment sample of children in Philadelphia, Dore, Wilkinson, and Sonis (1992) found that in spite of the availability of a range of services (i.e., partial hospitalization, home-based care, and outpatient therapy), the level of care the youths received was determined by their mental health treatment history, not by their current degree of need or dysfunction.

In addition to theoretical and conceptual barriers to understanding service utilization and mental health status are measurement issues. To date, no universally accepted measures or typologies of service utilization exist (Burns, Angold, & Costello, 1992) and those that do are generally based on adult populations (Smith & Loftus-Rueckheim, 1993). For children and adolescents, however, utilization is most frequently reduced to either a narrow measure drawn from a single service category (e.g., a "bed-day") or a very broad measure that fails to

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distinguish among service categories (e.g., "ever used mental health services"). Additionally, work on "patterns" of utilization typically relates gross measures of utilization to demographic and limited clinical factors such as diagnosis (Cohen, Kasen, Brook, & Struening, 1991; Zahner, Pawelkiewicz, DeFrancesco, & Adnopoz, 1992; Mason & Gibbs, 1992; Bui & Takeuchi, 1992; Burns, 1991). Yet, researchers have noted the importance of assessing a youth's strengths (e.g., competence) as well as weaknesses (e.g., psychopathology) (Kovacs, 1989), and considering the important role the family plays in dealing with troubled youths (Friesan & Koroloff, 1990; Stroul & Friedman, 1986).

Rationale

The present study attempts to fill gaps in research on children's mental health services by a) identifying and categorizing patterns of service utilization among children and adolescents, and b) relating these patterns to more comprehensive measures of mental health than simply the psychiatric diagnosis of the child. The intended product is an empirically derived typology of patterns of service use, developed to explore the relationships between utilization and these multidimensional measures of mental health status.

Method

Sample

Data were collected through the Fort Bragg Evaluation Project (FBEP). (See Behar, 1990; Bickman, Heflinger, Pion, & Behar, 1992; and Heflinger, Bickman, Lane, Keeton, Hodges, & Behar, 1992, for a more detailed description.) Participants in the FBEP are youths aged five through seventeen who are eligible for benefits through the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS) and receiving formal mental health services. The current analysis is based on the first 396 cases who entered the FBEP. The sample is 65% male, with a nearly equal distribution across the four age groups: 5-7 years, 8-11 years, 12-14 years, and 15-17 years. While predominantly white (73%), 16% of the youths are African-American, with the remaining 11% of mixed or other racial backgrounds.

Measures of Mental Health and Family Functioning

Mental health status of the youths was conceptualized multidimensionally and included measures of psychopathology, social competence, and level of functioning.

This research is supported by the U.S. Army Health Service Command (DADA 10-89-C-0013) as a subcontract from the North Carolina Department of Human Resources/ Division of Mental Health, Developmental Disabilities and Substance Abuse Services, and a grant to Dr. Leonard Bickman (R01MH-46136-01) from the National Institute of Mental Health.

Recognizing the important role the family plays in dealing with mental illness, indicators of family functioning as well as the burden families perceive as a result of caring for their child were included. Data were obtained by the Evaluation Project from the youth's primary caretaker at the time of intake to treatment.

Unsurprisingly, nearly all youths (98%) met criteria for at least one diagnosis as measured by Vanderbilt University's modification of the P-CAS – a parent version of the Child Assessment Schedule (Hodges, McKnew, Cytryn, Stern, & Kline, 1982). On the CBCL – the Child Behavior Checklist (Achenbach & Edelbrock, 1983; McConaughy & Achenbach, 1988), 65-75% fell in the clinical or borderline range of at least one of the four global measures of mental health (competence, total behavior problems, internalizing and externalizing behavior problems). Global Level of Functioning (GLOF) scores (Bird, Canino, Rubio-Stipec, & Ribera, 1987) suggested 75% of the sample had at least moderate impairment, while 18% suffered from major impairment or inability to function in almost all areas of living. Child and Adolescent Functional Assessment Scale (CAFAS) scores (Hodges, Bickman, Kurtz, & Reiter, 1992) indicated that from six months to five years of treatment would be required for at least three-fourths of the youths. Family Assessment Device (FAD) measures (Miller, Epstein, Bishop & Keitner, 1985) showed that over half of the families were functioning with significant difficulty. Virtually all respondents experienced at least some burden associated with the care of the youth in treatment on the Burden of Care Questionnaire (BCQ) (Brannan, 1992).

Measures of Service Utilization

Measures of service utilization were based on two sources – a management information system (MIS) that records each service encounter or contact and CHAMPUS claims data provided by the office of the U.S. Army Health Care Studies and Clinical Investigation Activities (U.S. Army, 1992) of the Health Services Command. Both databases provide measures of the number of outpatient visits, days of day treatment/in-home services, group or therapeutic home days, residential treatment center days, hospital days, and support service transactions.

Table 1 shows the operational definitions of the six types of services explored. For analytical purposes, units of services **within** each type

Table 1
Operational Definitions of Mental Health Services

Hospitalization	Days in a psychiatric hospital or psychiatric bed in a general hospital. Units: 24-hour days
Residential treatment facility	Days in a residential treatment center or specialized treatment facility. Units: 24-hour days
Group home/ therapeutic home	Days in a therapeutic home or group home with a specially trained family and/or support staff. Units: 24-hour days
Day treatment/ in-home services	Days of various intensive services in the home or specialized day treatment program. Units: 8 hour days or less
Outpatient therapy	Sessions of outpatient therapy (individual, group, or family) provided by a licensed mental health professional. Units: Encounters or sessions
Support services	Treatment-related encounters through a variety of indirect services, such as treatment team meetings, consultations, telephone referrals, case management, transportation and telephone screening. Units: Encounters or sessions

are aggregated so, for example, a child who received 7 days of group home and 14 days of therapeutic foster home care received 21 units of that type of service.

Analysis

The analysis presented here is two-fold. First, cluster analysis was used to identify cases with similar patterns of utilization based on the types of services described in Table 1. Second, discriminant analysis was used to identify which mental health status measures best predicted particular patterns of utilization.

Cluster Analysis

Cluster analysis of cases (Aldenderfer & Blashfield, 1984), sometimes called "numerical taxonomy," is a method for creating clusters of cases, based upon numerical similarity alone, with the maximum variance between groups and the minimum variance within groups. In exploratory stages of research, a cluster analysis can be used to describe a whole sample in terms of a few common types. The present study uses Ward's method (Ward, 1963) with squared Euclidean distance and 10% trim which removes the most atypical 10% of cases from clustering in order to permit more coherent clusters (Sarle, 1983).

Discriminant Analysis

To study the relationship between clinical status and service utilization, the thirty-five variables listed in Table 2 were chosen initially as those in the FBEP's data set that would be most appropriate for this study. Mental health variables which had no significant correlation with utilization were dropped, as were variables that had linear dependence on other variables, making them unfit for multivariate analysis. Twenty-one variables were used in discriminant analyses relating service clusters to mental health status. After cases with any missing mental health data were dropped, 281 cases remained, resulting in an adequate ratio of 13 subjects per variable (Edwards, 1976).

Results of the study will be presented in two stages, following the analytic plan outlined above. First, utilization patterns derived from the cluster analysis are described. Next, predictors of service utilization that emerged from the discriminant analyses are presented and clinical profiles of the youths are discussed.

Results of Cluster Analysis

The analysis statistically generated seven clusters which were interpreted and named by inspecting each cluster's means on the six utilization variables used to create them. Cluster analysis suggested that the utilization patterns of the sample could be described as follows:

1. ***Low users, (N=122).***

This cluster is comprised of cases who used few services. Ninety-two percent of this group used no inpatient services, 98% used no residential services, 100% used no group home services, 100% used no day treatment or in-home counseling. Twenty-nine percent used no outpatient services and the remaining 71% used 10 sessions or less. This group included youths who did not return after an intake session as well as those who participated in a limited number of direct clinical services.

2. ***Moderate users of outpatient services, (N=136).***

Within this group of moderate users, 100% used no inpatient days, 95% used no residential days, 97% used no group home days, 96% had no day treatment, 74% had 11-30 outpatient sessions. These cases experienced a moderate frequency of supportive contact (45% had 1-10 contacts, 44% had 11-30 contacts).

3. ***Heavy users of outpatient services with low to moderate support, (N=43).***

Sixty-seven percent of these cases had 31-70 outpatient sessions (on average, more than 1 per week), and 28% had 11-30 outpatient sessions. This group also used supportive services: 95% used some, with the mode (42%) having 11-30 supportive contacts.

Table 2
Measures of Mental Health, Competence, and Family Functioning

Mental Health Measures	Status for Discriminant Analysis
PCAS42 Total Attention Deficit Symptoms	NS
PCAS41 Total Conduct Disorder Symptoms	Used
PCAS44 Total Dysthymia Symptoms	NS
PCAS51 Total Endorsed All Items	Used
PCAS63 Total Endorsed Not DSM Related	Dependent
PCAS43 Total Major Depression Symptoms	Used
PCAS49 Total Number Of Any Diagnosis	Used
PCAS47 Total Oppositional Symptoms	Used
PCAS46 Total Overanxious Symptoms	NS
PCAS45 Total Separation Anxiety Symptoms	NS
CBCL25 Total Aggressive t-score	NS
CBCL20 Total Anxious/depressed t-score	NS
CBCL23 Total Attention Problems t-score	Used
CBCL24 Total Delinquency t-score	Used
CBCL33 Total Externalizing t-score	Used
CBCL31 Total Internalizing t-score	NS
CBCL29 Total Problem t-score	Used
CBCL21 Total Social Problems t-score	NS
CBCL18 Total Withdrawn t-score	Used
Competence Measures	
CAFAS3 Behavior Towards Others/self	Used
CAFAS8 CAFAS Total Score	Used
CAFAS6 Caregiver Resources Basic Needs	Missing
CAFAS General Level of Functioning	Used
CAFAS4 Moods/emotions	Used
CAFAS1 Role Performance	Used
CAFAS5 Substance Use	Used
CAFAS2 Thinking	Used
CBCL5 Activities t-score	NS
CBCL8 Competence t-score	Used
CBCL7 School t-score	Missing
CBCL6 Social t-score	Used
FAD General Functioning	NS
BCQ Objective Burden	Used
BCQ Subjective External Burden	Used
BCQ Subjective Internal Burden	NS

Note: "Used" variables were included in the discriminant analysis. "N.S." variables were nonsignificant in MANOVA and dropped. "Missing" variables were dropped because of excessive missing values. The "dependent" variable had linear dependency on other variables and was dropped.

4. ***Heavy users of inpatient services with substantial inpatient utilization, (N=39).***

The cases in this group averaged 35 days in a hospital; they had total inpatient days ranging from 13 to 88 days. None of them had any residential treatment, group home, or intensive day services. Seventy-seven percent used some outpatient services, the mode being 1-10 sessions (48%). Only 5% had any supportive contacts. This group is of moderate size, but has a dramatic impact on health care costs.

5. ***Heavy users of residential treatment centers, (N=6).***

These cases utilized 110 to 181 residential days with almost no use of other services. This cluster was dropped from subsequent analysis because of its small number of cases.

6. ***Intensive support with outpatient, (N=10).***

This group had an average of 78 supportive contacts, about three per week, with a range from 60 to 96 total contacts. These cases typically used a large number of outpatient therapy sessions (mean = 49 sessions) and a modest amount of inpatient and intensive day services. These cases used no residential treatment and no group home days in the study period. This cluster also was dropped from subsequent analysis because of its small number of cases.

7. ***Outliers, atypical heavy users (N=40).***

The cluster analysis trimmed the worst fitting 10% of the sample from the analysis in order to find coherent groups. On the average, this group used all services heavily: an average of 24 inpatient days, 36 residential treatment days, 49 group home days, 29 days in day treatment or in-home counseling, 76 outpatient sessions, and 127 supportive contacts. Because its utilization patterns are diverse and atypical, this group is dropped from further analysis.

Results of Discriminant Analysis

With four meaningful patterns of service use remaining, discriminant analysis was used to study the relationship between utilization and the mental health status of the youths and their families' dynamics. Since a four-group discriminant analysis would be extremely difficult to interpret, two-group discriminants were conducted on each cluster. In the first analyses, for example, cases were classified as "low users" (1) or "not low users" (0). Then a stepwise two-group discriminant analysis (Norusis, 1990) was conducted; mental health variables with a Wilks lambda significant at the 5% level were accepted.

Low users of all services.

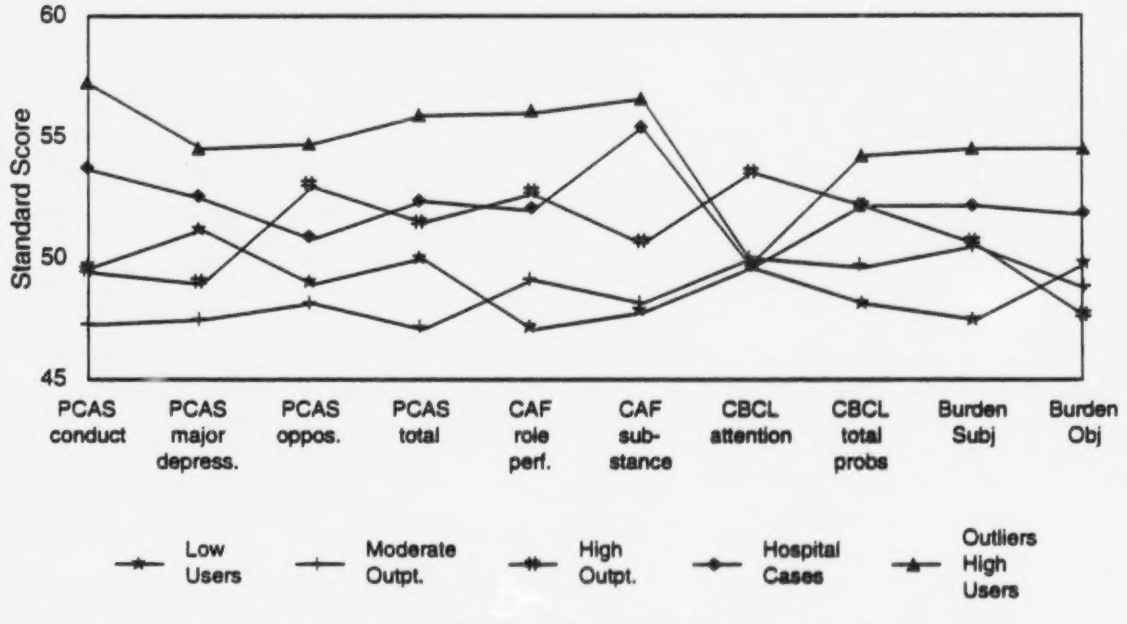
The results in Figure 1 show that low users (compared to the rest of the sample) had lower subjective externalizing burden reported by the primary caretaker, the children were more competent in role performance and experienced more symptoms of major depression.

Moderate users of outpatient services.

The same analysis, repeated for the moderate outpatient users compared to the rest of the sample, suggested that moderate users had fewer total problems on the P-CAS, fewer

Figure 1

Patterns of Utilization: Discriminating Mental Health Measures



conduct disorder symptoms on the P-CAS, and a lower total problem score on the CBCL than the rest of the sample.

Heavy users of outpatient and support services.

Heavy outpatient users were characterized by higher scores on attention problems (CBCL), lower scores on objective burden, and higher scores on oppositional symptoms (PCAS).

Heavy inpatient users.

Inpatient users, as opposed to the rest of the sample, were higher on only one variable: substance use (CAFAS).

Discussion

The results of the discriminant analysis reported above showed that youths with more serious types and levels of problems tend to receive more intensive services than less troubled youths. The low users of all services were primarily preadolescents characterized by better behavior, or at least a relative absence of disruptive behavior, compared to the remainder of the sample. Their parents reported feeling less resentment and anger toward these children, relating better to them, and experiencing less embarrassment. The majority of the children (i.e., 65%) had only mild or no impairment in role performance. This suggests that the child could be managed satisfactorily at home and in a community school, had no delinquent behavior, and an absence of persistent problems at school or at work. When impaired, it was typically at a mild level, indicating insufficient compliance with rules at school or in the home. However, the parents reported that these children had more depression symptoms corresponding to those listed for Major Depressive Episode in DSM-III-R (American Psychiatric Association, 1987). In fact, 46% of this group were rated as moderately or severely impaired on the Mood subscale of the CAFAS. Thus, these children have considerable depressive symptomatology but apparently acceptable behavior otherwise.

Further study of the low use group seems warranted to determine why these clients received so few services and to follow the course of their symptomatology. Half of the clients in this group had fewer than three therapy sessions, with the remaining half receiving three to 10 sessions. Perhaps the absence of parental negative feelings toward the child and the absence of behavioral problems contributed to the low level of services. In any case, this is worrisome given the longitudinal data on childhood depression. While depressive symptoms typically seem to remit with the passage of time, two-thirds of juveniles who receive a diagnosis of depression develop at least one new episode of depression before adulthood and may show residual impairment in social and academic functioning (Kovacs, 1989).

The moderate users of outpatient services are noteworthy for their relative lower overall pathology, as seen in fewer total symptoms on both the CBCL and the PCAS. These findings are consistent with the impairment data from the CAFAS, which indicates that the majority of these children (i.e., 57%) had no or mild impairment in role performance. The observation that they had fewer symptoms indicating conduct disorder is probably secondary to the fact that they are predominately preadolescents. The clinical pattern identified for this group appears consistent with the treatment they received. Three-quarters of these children received outpatient therapy sessions for three and one half to six months, at a rate of approximately one session per week.

The group of heavy users of outpatient and support services appears to be characterized by disruptive behaviors typically observed in preadolescents, specifically attention related problems and symptoms consistent with the *DSM-III-R* diagnosis of oppositional defiant (e.g., often angry, resentful, spiteful, and non-compliant). The majority of these children were preadolescent and were impaired in role performance, indicating difficulty being managed at home or in school (i.e., 60% at the moderate or severe level). Thus, while their symptoms were typical of preadolescents, their impairment was marked.

With the exception of the outlier group, these children received the highest number of outpatient sessions as well as the highest number of supportive services. Two-thirds of this group received more than one outpatient session per week, and 95% of them received supportive services. For both attention deficit-hyperactivity disorder and oppositional defiant disorders, parental involvement in treatment is essential to teach management skills (Barkley, 1989) or to participate in family therapy (Foster & Robin, 1989). In addition, there is consensus in the literature that treatment for attention deficit-hyperactivity should be multimodal, typically including behavior therapy in the home and at school as well as medication (Conners & Wells, 1986). Thus, the high number of support services and outpatient visits appear warranted given the clinical presentation of these children.

In the present study the only variable that distinguished the inpatient hospitalization cluster from the remaining clients was substance use. On average, the children in the inpatient hospitalization group spent 35 days in the hospital, with none receiving residential treatment, group home, or intensive day services. Similar to the outlier group, 80% of this sample are adolescents (i.e., 12 or older). Almost half of this group had some impairment due to substance use, with almost a third being impaired at the moderate or severe level. For an adolescent to qualify for moderate impairment, substance use was responsible for one of the following: interfering with functioning at school, on the job or while driving; resulting in trouble (e.g., fights, accidents, injuries, trouble with teachers/police, or health problems), or being high or intoxicated once a week. That hospitalized youths were distinct from others in their substance use may not generalize to other samples. On the other hand, this may reflect the proliferation of inpatient treatment programs for substance abusers - driven by the profit motive with no proven efficacy (Newcomb & Bentler, 1989; Bickman & Dokecki, 1989).

The outlier group consisted of clients who were high users of multiple services, with no common pattern. For this primarily adolescent group, every form of restrictive care was reported, including inpatient hospitalization, residential treatment, group home, and day treatment or in-home counseling. They were the most impaired, with 78% being moderately or severely impaired in role performance. Yet, compared to the inpatient hospitalization group, only half as many were impaired because of substance use. Since the outliers did not form a cluster by definition, no variables were identified that distinguished them from the remainder of the sample. However, it is noteworthy that this group had the highest scores, in the direction of pathology, on all variables, except for attention problems. Given that this group contained the most functionally impaired adolescents in the sample, further study of their long term utilization of services and the relative cost of treating them is warranted.

With little exception, the positive relationship between severity of mental health and intensity of service is confirmed. This correspondence lends support for the use of special statistical techniques to empirically derive patterns of service utilization for children and adolescents.

Summary and Conclusions

Research on the mental health delivery system for children, like those it is intended to help, is still young. Questions about its effectiveness or ability to provide services appropriate to the diverse needs of youths abound. One very preliminary, yet important, task pertains to the conceptualization and operational definition of service use. In this work, we have tried to capture the complexity and diversity of the treatment experience by including all services a client had received for a six-month period subsequent to intake to treatment. Cluster analysis was used to identify typologies or patterns of service utilization. Discriminant analysis identified those mental health status and family measures that best predicted service type. The expected correspondence found generally between service pattern and mental health profile provides evidence for the validity of the technique. Additional applications of this method are warranted to support its generalizability. Moreover, further investigation is needed of the related mental health needs of youths and their families. Nonetheless, empirically derived typologies of service utilization show promise for further exploration of service use as well as related issues in the field of children's services.

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Evaluation Of Kentucky Impact At Year Two: A Summary Of The Findings

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Introduction

The Kentucky Interagency Mobilization for Progress in Adolescent and Child Treatment (IMPACT) was enacted by the Kentucky legislature in 1990. The program stipulates that state and federal funds be accessed to provide more appropriate community-based services for children and youth with severe emotional disabilities. Emphasis is placed on interagency coordination, comprehensive service delivery, and limitations on the use of psychiatric hospitalization. Kentucky IMPACT has a number of program components jointly administered by the three major departments within the Cabinet for Human Resources and the Department of Education, and is coordinated by a State Interagency Council (SIAC). At the regional level, services are developed, coordinated and administered through Regional Interagency Councils (RIACs). Core services in each region include: (1) interagency treatment planning teams; (2) targeted case management services; and, (3) individual family-based support services (IFBSS, also called "wraparound" funds) used at the discretion of the RIAC when children's needs cannot be met with existing resources but require that creative, individualized services be "wrapped around" the child. Additional service components that are gradually being developed around the state, but are not yet available in every region, include: (1) family preservation programs; (2) intensive in-home services; (3) services to multi-problem children in private child care; and (4) small community-based psychiatric residential treatment facilities (PRTFs).

This formative evaluation delineates information available regarding a range of process and outcome variables within Kentucky IMPACT, which has now completed its second year of operation (see Illback, 1991, for the evaluation of year one of program operation). The IMPACT evaluation plan is internally-focused and management-oriented, seeking primarily to utilize data from the management information system (MIS) for the purpose of program development and improvement. Emphasis is placed on a central set of evaluation questions organized around demographic (Who is being served?), service delivery (What services are being delivered?), and outcome (What changes are associated with program participation?) dimensions. The evaluation relies on a repeated measures design, in which participant functioning is measured at intake, six months, and twelve months. This design provides the greatest degree of experimental control and rigor possible, given that it was deemed infeasible to randomly assign eligible children to treatment and control groups. A weakness of the design is that it does not provide for a direct contrast with an equivalent group of children who do not receive the treatment. Rather, the design relies on reviewing within-subject trends to assess change across multiple measures.

Who is being served by Kentucky IMPACT?

As of October 1992, data were available from the management information system at the Kentucky Department of Mental Health on 960 children and youth. Of these children, 208 were served by the Bluegrass IMPACT program, which receives additional funding through the Robert Wood Johnson Foundation. Bluegrass IMPACT is the original system of care project in the state, operating across a 17-county region in central Kentucky, and funded (in part) by a four-year implementation grant from the Robert Wood Johnson Foundation. The entire state adopted this approach in 1990, and the Bluegrass project is now a part of the overall statewide initiative (Kentucky IMPACT).

Demographic Characteristics

The distribution of individuals served by Kentucky IMPACT heavily favors boys over girls in the aggregate and the overall group tends to favor early adolescents beginning at approximately age 12 and extending through age 16. When these numbers are aggregated in terms of age ranges, it becomes even more apparent that early adolescents are the primary group of individuals being served by the program.

It is interesting to note that boys are dramatically over-represented in the earlier age ranges, but by late adolescence, girls are beginning to catch up in their representation within the sample. This finding implies that it is both girls and boys (with girls in increasing numbers) that place stress on the system in the adolescent subpopulation. It may be useful to consider in more detail the implications of problems girls experience, in contrast with those presented by boys. A plausible hypothesis (based on preliminary analyses) would seem to be that more complicated and late-emerging problems (particularly for girls) are the areas that are prominent with adolescents and cause intervention to become more complex and difficult for the program.

Child and Family Risk Factors

Risk factor data reflect the extreme complexity and multi-problem nature of the situations faced by these children and families. Most notably, over two-thirds of the sample have problems in learning, and well over 50% come from conditions of poverty, divorce, family violence and family chemical dependency. Additionally, over 50% have had a prior psychiatric hospitalization and exhibited behavior that is considered dangerous to others. Approximately one-third have been physically or sexually abused, about the same percent come from families in which there is a history of mental illness, and many live in situations where there are negative peer influences that affect behavior.

When risk factor data are examined relative to sex, some interesting differences emerge that relate both to developmental and societal factors. On the one hand, girls appear far more likely to have experienced sexual abuse and to have made suicidal attempts. This seems consistent with a higher proportion of internalizing behavior.. Likewise, boys appear more prone to experience below grade level achievement and chronic suspension and/or expulsion from schools. They also are more prone toward acting-out behaviors such as firesetting, aggression towards others, and sexually abusive behaviors. On all other variables there do not appear to be any systematic differences that can be interpreted. In fact, it appears that girls are slightly more likely to have had prior hospitalizations.

An exploratory analysis of risk factors for the total population was completed using agglomerative cluster analysis. It appears that there are at least 3 underlying clusters for the risk factors within the initial 960 cases. The first cluster appears to revolve around problems associated with family stressors and lack of social support. Approximately 515 cases seem to be most closely associated with this pattern. The second cluster has been named child/family violence and psychopathology ($n = 227$), and appears associated with families where aggression, mental illness, substance abuse, and related dysfunction are salient. Finally, a cluster that emphasizes families that have disintegrated (or are unavailable to the child) is seen. Within this cluster, most of the children appear to be system-dependent, meaning they are heavily involved with services that are closely reliant on the service system. It is important to emphasize that these interpretations are tenuous and probably do not have complete explanatory value relative to the complexity of the database they seek to portray.

Primary Diagnoses

A considerable portion of this sample is derived from children with disruptive behavior disorders. Ten percent appear to have conduct disorders, 20% have the diagnosis of Attention Deficit Hyperactivity Disorder and almost 25% are diagnosed with Oppositional Defiant Disorder. Mood disorders are also highly represented in this sample. Over 10% appear to experience major depression, and other depressive disorders appear to account for another 8%. A third major category encompasses anxiety disorders. These seem to be less represented in the sample with the exception of post-traumatic stress disorder, presumably associated with children/adolescents who have experienced abuse or other trauma. Another relatively small proportion of the sample is portrayed in the psychotic disorders including schizophrenia and related diagnoses. Together, these account for approximately 3% of the sample. The remaining cases are distributed unevenly between adjustment disorders, problems of identity and attachment, developmental disorders, and personality disorders.

How are services being delivered?

The IMPACT information system tracks specific services delivered by quarter within broad categorical areas such as case management, counseling, support services, education, therapeutic day services, crisis response, and residential services. Additionally, when an eligible child leaves the program, their reason(s) for exiting are tracked. The following sections summarize some of the more interesting trends rated.

Patterns of Service Delivery

As might be expected, over time the scope and intensity of various case management functions diminish, with a concomitant increase in monitoring. However, out-patient therapy and psychotropic medication are maintained at a relatively even rate over time, and some support services (e.g., respite and wraparound aides) maintain at a relatively high level or increase. School services do not appear particularly altered during the course of treatment, crisis response services remain at a high level, and foster care and long-term hospitalization rates begin to increase in the latter portions of the intervention.

Exiting Patterns

To date, 263 of the 960 individuals who were accepted into the program have exited. It appears that: (1) about one-fourth exit because they have completed the IMPACT Program; (2) about one-third move to another location; (3) in about one in five cases the family elects to terminate their involvement with the IMPACT Program although their goals have not been completed; and, (4) about one in four provide some other reason for ending their involvement. Notable among these findings is the fact that only a small proportion of the exits are attributable to goal attainment.

These data support evidence from the initial evaluation to the extent that involvement with IMPACT extends for longer periods of time than originally anticipated, affecting service coordinator caseload turnover rates. In all likelihood, this is a function of the severity and complexity of problems experienced, but nonetheless presents a persistent programmatic challenge. Of some concern is the relatively high (17.5%) percentage of cases in which families elected to discontinue involvement with IMPACT, not because goals were attained or needs met, but rather because they wished to no longer avail themselves of the service. An important managerial task is to establish the reasons underlying this rate for a sample of cases and identify ways in which it can be reduced.

What outcomes are associated with participation in Kentucky IMPACT?

This section delineates outcome-related information relative to a number of variables, including: (1) social competence and behavior problems; (2) restrictiveness; (3) placement stability; (4) family support; (5) social validity; and, (6) cost-efficiency.

Social Competence and Behavior Problems

Fundamental to a judgment about program efficacy is whether meaningful behavior change occurs. To assess this, the evaluation utilizes the Child Behavior Checklist (CBCL), the most prominent and widely used measure of social competence and behavior problems for clinical-child populations. Analysis of data available to date is compelling; substantial, positive changes occur in the reduction of behavior problems.

This finding is illustrated by examining Table 1, which depicts means and standard deviations for three interval measurements of the CBCL: intake, six months, and twelve months. These data relate to individuals for whom complete data sets are available ($n = 153$). When subjected to a repeated measures multiple analysis of variance (MANOVA), exceptionally strong effects are noted for overall behavior (*Sum T*), as well as both internalizing and externalizing behavior. Most of these gains appear to occur by the second measurement (six months). Significance is not reached on any of the social competence variables.

Restrictiveness

One of the primary hypotheses underlying Kentucky IMPACT is the belief that, as a consequence of participating in community-based programming, children and youth will be more likely to live in less restrictive settings. The present evaluation strategy requires service coordinators to rate restrictiveness at intake, six months, and twelve months.

An examination of the total restrictiveness scores for the group shows a statistically significant decrease in restrictiveness for the first 6 months of the intervention, but this effect reverses itself over the second interval of the intervention. Thus, when the subsample for whom one year's data was available is reviewed, significant change is not noted.

Overall, it appears that there have been some changes within the distribution relative to the kinds of settings in which children are placed, but the net effect is not (at least to date) a reduction in overall restrictiveness. Within the distribution, it is clear that the effect of a meaningful decrease in psychiatric hospitalization is durable. This is accompanied by increases in the use of therapeutic foster care, decrease in the use of adoptive homes, and an increase in Department for Social Services (DSS) residential programs. While the intervention has increased placement stability (see later section), it has not increased living with natural families.

Table 1
CBCL MANOVA Means and Standard Deviations at Intake, Six Months, and One Year
(*n* = 153)

	T1		T2		T3	
	M	*SD*	M	*SD*	M	*SD*
Social Competence						
Total	22.967	14.706	23.405	15.212	23.026	16.363
Activities	39.255	12.842	40.268	13.188	39.647	13.262
Social	27.889	13.972	28.582	14.894	30.252	14.029
School	21.771	14.577	24.660	14.883	23.974	14.958
Behavior Problems						
Sum	76.739	9.487	73.314	10.367	70.412	10.405
Internalizing	71.183	8.787	68.137	9.791	65.137	10.430
Externalizing	74.340	8.623	71.490	9.257	69.288	10.716

Placement Stability

Relative to the year prior to the intervention, a subsample of individuals for whom a year of data is available reflected substantial decreases in number of placements. More specifically, a higher percentage of individuals experienced only one placement rather than multiple placements following placement in the IMPACT Program. When subjected to statistical analysis (paired samples *t*-test), a statistically significant change is evident. This is, of course, a positive finding, since placement instability has been shown to have deleterious effects on children and greatly exacerbates the ability of providers to deliver effective services.

Family Support

There is considerable research evidence to the effect that families with children with severe emotional disturbances (SED) experience stress at a high and persistent level. In addition to helping parents change the problem behaviors experienced by their children, IMPACT seeks to provide support and empower families. Therefore, the evaluation design seeks to measure the extent to which families: (1) experience a higher density of social support from both informal and formal sources as a consequence of program involvement; and (2) are satisfied with the timeliness and responsiveness of the support they receive from these sources. An examination of these data is central to understanding whether meaningful systemic change has occurred, and the probability that it will be maintained.

Table 1 portrays means and MANOVAS for a sample of individuals for whom complete data sets were available on the Inventory of Social Support (*n*

= 177), reflecting intake, six month, and one year intervals. These data indicate that positive change is detected for density of support from other relatives, services coordinators, respite providers, crisis counselors, recreation workers, in-home workers, and for total social support. This provides strong and compelling evidence of the extent to which IMPACT serves as a source of social support for families.

Table 1 also portrays the means and MANOVAS for a sample of individuals for whom complete data sets were available on the Family Support Satisfaction Scale (*n* = 177). These data indicate that positive change is detected for satisfaction with support from co-workers, service coordinators, respite providers, crisis counselors, recreation workers, in-home workers, and for total social support. Similar to the finding for the Inventory of Social Support, these data provide convincing evidence of the extent to which families perceive IMPACT services as vital, and are satisfied with these services.

Social Validity Measures

Parents, service coordinators, teachers, and children were asked to rate child progress along dimensions such as: (1) behavioral self-control, (2) emotional adjustment, (3) relationship skills, (4) educational achievement, and (5) school adjustment. All report highly favorable results, confirming that for the individuals involved, the program appears to have validity. In conjunction with the findings regarding positive behavior change, these data can serve to corroborate that meaningful change has occurred.

Cost-efficiency

An analysis of estimated costs for service delivery arrays within a range of settings was conducted, based on Division of Mental Health data and service utilization rates. The analysis compares the prior year's cost for participating youngsters with the first year of involvement in the IMPACT Program. By multiplying the average number of days in various settings times the typical per diem for the service array associated with that setting, an approximation of the cost per child to the system of services was calculated. This analysis includes estimates of the cost of supporting children to live with their natural families in the community. An approximation of the cost per child for services in the year prior to program involvement is estimated at $16,987. The estimated cost for the first year of involvement in the Kentucky IMPACT program is $12,722 representing a savings of about $4,200 per child. Extrapolating to the total population served, a net savings of over $4 million can be estimated.

Summary

Kentucky IMPACT continues to demonstrate that it is an effective, cost-efficient program. Children, youth, and families are experiencing significant gains on important dimensions such as placement stability, behavior problems, and social support. While program managers must attend to a variety of implementation problems, including improving intervention durability, reducing restrictiveness, and increasing informal support to families, the program is sound and worthy of on-going support.

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Preliminary Findings From Program Evaluation Research on The North Idaho Child and Adolescent Service System Project

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Introduction

The congressionally authorized NIMH-CASSP projects are guided by a "system of care" philosophy (or conceptual model). According to this philosophy, the public services addressing multiple levels of child functioning should be comprehensive, integrated, individualized, least restrictive, designed with maximum parent participation, culturally appropriate, and coordinated through interagency case management (Stroul & Friedman 1986).

NIMH further expressed a strong desire for mental health services that were community-based rather than institutional (residential). Within a community-based continuum of care model, the child and family's needs rather than conventions related to service sectors should be the basis for intervention (Stroul & Friedman 1986). This principle is evident in "wrap - around services" wherein service dollars flow across funding categories.

Under NIMH auspices, an independent 10 state qualitative evaluation of the first 5 years of CASSP demonstration projects was conducted in 1989. From retrospective qualitative evidence (including interviews of key staff), the investigative team concluded that state level developments were in the direction of CASSP goals (Schlenger, Etheridge, Hansen, & Fairbank, 1990).

Research-based knowledge about community alternatives to institutional care for SED children is beginning to emerge from CASSP demonstrations across the country. The present study offers one illustration. We report preliminary findings from a CASSP rural demonstration, the North Idaho CASSP project.

Purpose

The ultimate purpose of the North Idaho CASSP research is to assess intervention effects by comparing a pilot group receiving community-based services to a comparison group receiving residential services in terms of the standardized measures of psychosocial and family functioning, and satisfaction with services. However, because we have so few cases at this time in the comparison group, the major focus of this preliminary report is the pilot group receiving community based services. The service strategy for the community based pilot group was designed in terms of the principles described above for all CASSP projects. The particular service offerings in the pilot group include family therapy services, the use of wraparound services dollars, treatment family services, respite family services, and classroom companion services.

Thus the purpose of this report is to offer preliminary findings on the effects of the North Idaho CASSP project for the pilot group receiving community based services. Specifically, we will report the results of comparisons across time for the pilot group in terms of FACES III, CBCL, TRF, and Family Satisfaction Scores. A related purpose is to describe the pilot group in terms of selected single variables and in terms of interesting associations among particular variables.

Measures

FACES III

FACES III is a self-report measure of family functioning on the dimensions of 1) cohesion or connectedness, defined in terms of the degree of emotional bonding and individual autonomy within the family and 2) adaptability or changeability defined in terms of the family's ability to change power structures, role relationships, and norms in response to stress (Olson, Sprenkle, and Russell, 1979; Russell, 1979). In the North Idaho CASSP project, FACES III is completed separately by a parent or parent surrogate, and by the clinical child.

As a result of recent research on FACES III by Green and his colleagues (Green, Harris, Forte, Robinson, 1991a; Green, Harris, Forte, Robinson, 1991b) and Olson's response to this research (1991) this report 1) treats the measure as linear rather than curvilinear and 2) presents findings exclusively on the cohesion subscale. Green and his colleagues' conclusion relative to our second point is that the adaptability subscale lacks concurrent validity. Specifically, the correlations between adaptability and two criterion measures were low for both husbands (*n* = 2,440) and wives (*n* = 1,780). The investigators report: "Because these nonclinical results are consistent with our earlier findings from a clinical sample of adolescents and their mothers...we retain our questions about the utility of the adaptability subscale as a curvilinear or as a linear measure" (Green, Harris, Forte, & Robinson, 1991b p. 82). Not surprisingly in view of this conclusion, Green and his colleagues also recommend that the two subscales never be combined to yield one FACES III score. Clearly since one of two subscales is now considered invalid, it makes no sense to combine them and speak in terms of "balanced, moderately balanced, mid-range, and extreme" family types.

High scores on the cohesion subscale range from 46 to 50. These high scores, following the recent linear interpretation of FACES III, are now reinterpreted as "very connected" rather than "enmeshed. Scores in the 41 to 45 range are interpreted as "connected"; scores in the 35 to 40 range are interpreted as "separated", and scores in the 10 to 34 range are interpreted as "disengaged."

CBCL and TRF

The edition of the CBCL and TRF that we use is 1991 in which the title has been changed to *Child Behavior Checklist for Ages 4-18* because the instrument has now been normed through age 18. The CBCL and TRF 4-18 year-old version has change little from its predecessors; its purpose remains that of providing descriptive information on a child's behavioral/emotional problems and competencies, as judged by parents and teachers or the like.

For the purposes of statistical analysis, we have used *T* scores rather than raw scores. *T* scores have been standardized to have a mean of 50 and a standard deviation of 10. Achenbach recently reported that "Because the total competence... and total problem scales were not truncated in the assignment of *T* scores, statistical analyses using *T* scores should yield results similar to those using raw scores" (Achenbach 1991, p 148).

We express our findings on the CBCL and TRF in terms of total scores rather than scores for subscales. The total problem score on the CBCL is the sum of the 8 scale scores (Withdrawn, Somatic Complaints, Anxious/Depressed, Social Problems, Thought Problems, Attention Problems, Delinquent Behavior and Aggressive Behavior scales). On the problem scales of the CBCL the borderline clinical range expressed in *T* scores is 67 to 70; for normative samples these scores cover the 95th to 98th percentile range. Higher *T* scores on the CBCL are clinically significant, indicating greater behavioral/emotional problems. *T* scores of 71 to 100 are in the clinical range on the CBCL problem scales.

The total competence score on the CBCL is the sum of the 3 scale scores (Activities, Social, and School scales). Whereas high scores are clinically significant on the CBCL problem scales, low scores are clinically significant on the CBCL competence scales. The borderline clinical range expressed in *T* scores is 37 to 40; for normative samples these scores cover the 10th to the 17th percentile range. *T* scores from 36 to 10 are in the clinical range of the CBCL competence scales.

The TRF scale scores for behavioral/emotional problems, four adaptive characteristics, and academic performance have the same borderline clinical ranges as the CBCL problem and competency scales.

Family Satisfaction

Finally, we are using a consumer satisfaction measure in the North Idaho CASSP project consisting of items selected by parent consumers of child mental health services in the state of Idaho. The Likert type measure indexes the intensity of parent satisfaction to each service received by the child with SED. The instructions for the parent satisfaction measure identify and describe each service separately. This description is followed by the same 14 items for each service. The parent responds to each of the items on a 4 point scale where 1 = poor, 2 = fair, 3 = good, and 4 = excellent. The intensity of parent satisfaction to each service is indexed by summing up parent responses to the items. The scores can range from 14 to 56, the highest satisfaction rating possible.

Preliminary Findings

Description of the Children

Data were available for the first 50 children served by the North Idaho CASSP project. There were 34 boys (68.0%) and 16 girls (32.0%). The mean age was 12.4 with a range of ages from 5 to 17. Sixty percent of the children were between the ages of 12 and 15. The racial composition of the children reflects that of the geographical area. One client was Hispanic, the others were Caucasian.

Twenty four (48.0%) of the families were intact two-parent homes, while in 24 (48.0%) families only the mother was present and in two (4.0%) families, only the father lived with the child(ren).

The mean number of previous out of home placements was 2.2. All children had at least one previous placement and five children had five previous placements.

Children's Problems

From state records on these children we identified the following troublesome patterns:

- 34 (68.0%) had a record of violence
- 28 (56.0%) had been physically abused
- 22 (44.0%) had a history of runaway behavior
- 19 (38.0%) were on psychotropic medication
- 22 (44.0%) had been sexually victimized
- 15 (30.0%) had a history of substance abuse
- 15 (30.0%) had a history of attempted suicide
- 6 (12.0%) had sexual behavior problems
- 4 (8.0%) had a history of fire setting

CASSP Services Received

While the principles of service delivery outlined above for all CASSP projects are subtle and all pervasive, the service offerings are easy to count. Children and their families in the community based pilot group received the following services:

- 38 (76.0%) family therapy services
- 28 (56.0%) wraparound services dollars
- 23 (46.0%) treatment family services
- 18 (36.0%) respite family services
- 11 (22.0%) classroom companion services

Children's Behavioral and Emotional Problems

Parents' perceptions of the children's behavior were measured using two dimensions of the CBCL. The mean of the CBCL total scores on the children's behavioral and emotional problems at the baseline period was 73.1. Three-fourths of the children scored 70 or above indicating that these children exhibited greater behavioral and emotional problems than 98% of the nonclinical normative samples. The subsequent time periods indicated a reduction in the means of the total CBCL problem scores and a decrease in the number of children scoring above 70, as shown in Table 1.

Turning to the CBCL total competency scores, we also observe improved functioning (See Table 2). The means CBCL total competency scores ranged from 32.1 at baseline to 37.3 on the 12

Table 1
Children's Behavioral and Emotional Problems
(CBCL Total T Scores)

Time	# Children	Mean	*SD*	70 or above
Baseline	50	73.1	11.1	76.0%
3 Months	16	68.8	14.8	50.0%
6 Months	19	67.4	9.2	53.6%
12 Months	14	68.6	8.6	42.9%

Table 2
CBCL Total Competency Scores

Time	# Children	Mean	*SD*
Baseline	42	32.1	6.8
3 Months	16	33.3	6.5
6 Months	16	34.2	7.4
12 Months	14	37.3	7.3

month tests. (Recall that whereas high scores are clinically significant on the CBCL problem scales, low scores are clinically significant on the CBCL competence scales.)

Teachers' Perceptions of Children's Behavior (TRF)

The mean rating by teachers on CBCL total problem scores also evidences a decrease over the four time periods, as shown in Table 3.

Thus, trends observed in the teachers' ratings support those observed in parent ratings. However, teachers tend to perceive fewer child emotional and behavior problems than parents. In fact, TRF problem scores were not statistically correlated with the CBCL problem scores. This suggests that parents and teachers differ in their perceptions of children's problems. This difference may also be due to differing behaviors at home and at school, among other possible explanations.

Family Relationships

Perceptions of the family in terms of cohesion as viewed by the child and the parent were obtained using FACES III. The means of both the parents and children were in the "Separated" or Disengaged" ranges (See Table 4).

Prior to the beginning of the intervention the perceptions of family cohesion by the parents were significantly more positive than those of the children (Paired *t*-test, $t = 4.27$, 42 df., $p = .000$). During the second and third time periods the children's mean scores on the FACES III appeared to differ little from their parents.

Comparison of the CBCL and FACES III

In order to determine the association between the scores on the CBCL and the FACES III, Pearson correlations were calculated on baseline data. The total score on the CBCL was significantly correlated with the child's perception of family cohesion as measured on FACES III ($r = -.3089$, $p = .019$). The relationship between the parent's perception of family cohesion and the total score on CBCL reached borderline significance also ($r = -.2385$ $p = .055$). These correlations indicate that families with higher cohesion scores were apt to have lower CBCL problem scores.

Paired T-test Analyses of Scales

Data on the CBCL and FACES were available for 50 children prior to the beginning of the intervention. There were data on 16 of the children at 3 months, 19 children at 6 months, and 14 children at 1 year. Because of missing data, paired *t*-tests were performed in addition to ANOVA on CBCL and FACES III scores. The *t*-tests allow us to assess changes through the first year of intervention for a larger sample of children. (Data for all four time periods were

Table 3
Teacher's Total Ratings on the TRF

Time	# Children	Mean	*SD*
Baseline	41	67.6	11.3
3 Month	8	65.4	13.6
6 Month	14	63.1	11.5
12 Month	9	60.9	9.8

Table 4
Family Relationships (FACES III - Cohesion)

	Parents			*Children*		
	N	Mean	*SD*	*N*	Mean	*SD*
Baseline	46	33.8	8.2	45	27.4	11.3
3 Months	15	33.1	8.3	13	32.5	9.4
6 Months	18	33.1	7.3	16	31.5	8.3
12 Months	11	37.7	6.4	10	35.2	6.7

available for only one child.) It must be remembered, however, that the children compared at 3 months were not necessarily the same as those included in the sample at 6 months or those sampled after one year. In addition, any time multiple t-tests are run, we increase the possibility of a Type I error. The findings on the paired *t*-tests are generally positive, showing improved child and family functioning (See Table 5).

Table 5
Significant Paired t-test

Variables	*N*	*t*	*p* (1-tailed *t*-test)
CBCL Baseline to 3 mo	16	2.93	.005
CBCL Baseline to 6 mo	19	3.72	.001
CBCL Baseline to 12 mo	14	2.93	.006
CBCL Social Competency Baseline to 12 mo	14	-2.21	.023
TRF Baseline to 6 mo	13	2.57	.012
FACES III Parents Baseline to 12 mo	11	-2.40	.018
FACES III Children Baseline to 12 mo	12	-2.16	.030

These findings suggest that there is a statistically significant decrease in the CBCL total problem scores early after treatment is provided. There appears to be less change between later time periods. However, the early reduction in problems is maintained. Similarly, improvement may also be observed in terms of CBCL total competency scores from baseline to 12 months. Finally, improvement may also be noted on the cohesion dimension of FACES III.

Changes in Teachers Perceptions

Changes in the teachers' rating of the children's behaviors are less clear. The TRF means at the 4 time periods indicate a reduction in the children's emotional and behavioral problems. While there was a statistically significant decrease in total problem scores from baseline to 6 months, this reduction was not evident at the 12 month test, perhaps because of the small sample size of eight children. A more accurate picture of the changes in the teachers' perceptions of the children's behaviors may be discernible with additional data.

Changes in Family Relationships

The parents and children had significantly increased their family cohesion scores from baseline to 12 months. The differences in cohesion scores between the baseline and first two time-tests were not significant, however.

These findings suggest that changes in family cohesion may be occurring at a slower rate than behavioral and emotional changes in the children. Only at the third time period, approximately one year after the beginning of the intervention, did the children and mothers perceive family relationships to be more cohesive or connected.

Family Satisfaction With CASSP Services

Using the project designed instrument described above, parents were asked to estimate their satisfaction with the following North Idaho CASSP services: family therapy, family treatment services, respite family services, classroom companion services and family companion services. The scores ranged from 40.1 to 48.4. In Table 6, the mean satisfaction scores are indicated for three time periods.

The satisfaction ratings were in the range of "good" to "very good" for all service categories. Parents evidently felt a moderately high level of satisfaction for the North Idaho services designed according to the CASSP principles described above.

It was hypothesized that parents would have more positive feelings toward the project when their children had fewer problems and

Table 6
Family Satisfaction

Service	3 months	6 months	12 months
Family therapy	45.9 (11)	44.6 (14)	47.3 (8)
Treatment family	43.4 (8)	40.1 (9)	43.4 (5)
Respite family services	42.8 (5)	48.4 (5)	48.0 (3)
Classroom companion services	46.0 (3)	46.7 (3)	41.8 (4)
Family companion services	41.0 (2)	41.8 (5)	45.2 (5)

the family appeared to be more cohesive. Means for the parents' satisfaction with the five CASSP community based services were used to provide an overall parent satisfaction rating at each time period. The means for the overall parent satisfaction ratings ranged between 43.6 to 44.4. The overall parent satisfaction ratings at 3 months were significantly related to the parents' perception of family cohesion ($r = .5029$, $n = 13$, $p = .020$). At 6 months the overall parent satisfaction ratings were significantly related to the child's perception of family cohesion ($r = .6053$, $n = 13$, $p = .007$).

CBCL Changes Across Three Times

Here and for all ANOVA analyses reported below, the data were first examined to determine if they met the assumptions for using this statistical test, i.e. normality, homogeneity of variance, and, when there were more than 2 levels on a factor, sphericity. All the ANOVA results reported here more or less met the above assumptions in the judgment of the researchers. Therefore we used univariate results which have greater statistical power to test the null hypotheses.

Data were available for analyses across three time periods for 7 cases in the pilot group, using CBCL problem scores as the dependent variable. The mean CBCL problem scores for these children suggested improvement in their functioning (baseline = 72.286 (*sd* = 3.773), 6 months = 68.714 (*sd* = 6.993), 1 year = 65.571 (*sd* = 8.810)). (Recall that higher scores are clinically significant.) Thus the null hypothesis that the children's' CBCL problem scores did not differ across time periods was tested. The univariate tests indicated significant mean differences across time (significance of $F = .022$). We therefore rejected the null hypothesis and concluded that the children in the pilot group had indeed improved, as measured by a reduction in their CBCL problem scores.

Having demonstrated improvement in terms of problem reduction we turned to the question of improvement in terms of competency development, as measured by CBCL competency scores. Here we failed to reject the null hypothesis that the competency scores for these same 7 children differed across the three time periods. An examination of the mean competency scores suggests an uneven pattern (baseline = 34.875 (*sd* = 3.671), 6 months = 37.571 (*sd* = 5.159), 1 year = 36.000 (*sd* = 5.916)). (Recall that lower scores are clinically significant.). Relative to FACES III scores for these 7 children, missing data prevented analysis.

CBCL Within and Between Subject Differences

Data were available for within and between group analyses on 2 factors (time and group) each having 2 levels. However, the community based service group was quite a bit larger (N=16) than the residential group (N=6). We note that the following results may simply be a product of these very unequal sample sizes.

Still, the comparison of means on the CBCL problem scores reveals interesting initial differences between groups. At baseline the mean total problem score for the community based service pilot group is well within the clinical range while the mean total score for the residential service group is merely in the borderline clinical range (baseline mean, community based service group = 76.438 (*sd* = 7.633); baseline mean, residential group = 69.000 (*sd* = 9.839)).

In terms of mean CBCL problem scores, it is also interesting to note that both groups showed improvement on the test given 3 months later. Indeed, at 3 months the mean total problem score would place the community based service group in the borderline clinical range while the mean total problem score for the residential service group places them entirely out of the range of clinical concern. However, the community based service group demonstrated much more improvement in terms of mean scores from baseline to three months than the residential group (3 month mean, community based service group = 68.750 (*sd* = 14.785); 3 month mean, residential group = 64.000 (*sd* = 14.375).

Assuming the conditions for using within and between subjects ANOVA were more or less met, we proceeded to test the relevant null hypotheses pertaining to the main effects of time and group and interactions effects. (We note that the sphericity condition is not relevant because the tests involve only 2 levels. For the same reason, the multivariate and univariate results of these tests are identical.)

Again, there is a significant effect for time (significance of *F* = .048), permitting us to reject the null hypothesis that there is no difference in average CBCL problem scores for children at baseline and 3 months. But the univariate results are not statistically significant for the effect of group (significance of *F* = .263). There is not sufficient evidence to warrant rejecting the null hypothesis as there is no difference in CBCL problem scores for children using community based services and children using residential services. Finally, we observed no interaction between the group and time period in terms of effects on CBCL problem scores.

Turning to the CBCL competency scores, the comparison of means again reveals interesting initial differences between groups. (Recall that low scores are clinically significant on the CBCL competence scales.) At baseline the mean total competency score for the community based service group is again well within the clinical range while the mean total score for the residential service group places them just one point short of falling in the nonclinical range (baseline mean for community based service group = 30.629, *sd* = 6.696, *N*=14; baseline mean for residential group = 40.333, *sd* = 3.055, *N* = 3).

In terms of mean CBCL competency scores 3 months later, it is also interesting to note that the community based service group showed improvement while the residential group evidenced a decline in social competencies (3 month mean, community based service group = 33.714 (*sd* = 6.638); 3 month mean, residential group = 39.000 (*sd* = 8.185).

Recognizing that the results may be due to small sample sizes (community based service group *n* = 14; residential group *n* = 3) or unequal sample sizes, we proceed to an exploration of the significance of these differences. The results indicate a significant effect for group (significance of *F* = .056), permitting us to reject the null hypothesis that there is no difference in CBCL competency scores for children using community based services and children using residential services. No significant main effect was observed for the time factor or for the interaction of time and group in terms of CBCL competency scores. In summary, with the above qualifications in mind, the type of services children with SED receive does seem to affect their overall competency.

Summary

Our preliminary analyses revealed a relationship between the CBCL scores and the family cohesion scores, suggesting that behavioral and emotional problems were inversely related to family cohesion. Parents and children seemed to perceive family cohesion similarly as measured by FACES III. The relationship between the family cohesion scores on FACES III of the parents and child was statistically significant. This suggests that parents and children may perceive family cohesion similarly. The preliminary findings, using paired *t*-test, with 50 children suggest that the

North Idaho CASSP project has been successful in improving the behavior of children with serious behavioral and emotional problems as measured by the total score on the CBCL. A similar improvement in social competency appeared after 12 months of intervention. Positive changes in the children's and the mothers' perceptions of the family functioning emerged after approximately a year of service as measured by FACES III. Improvements in the children's behavior as measured by the TRF were not stable, most likely due to the small sample size.

There was a moderately high level of satisfaction with the North Idaho CASSP project expressed by the parents as measured by the Family Satisfaction Instrument. The parent satisfaction ratings were significantly related to parent scores of the FACES III.

Conclusion

The results at this point in the North Idaho CASSP project offer grounds for guarded optimism. The intensive community based service project based on the NIMH CASSP model appears to improve children's behavioral and emotional functioning. Some evidence also suggests that family functioning also improves. Moreover, parents seem very satisfied with each of the components of North Idaho's community based service project.

All of the results must be seen as tentative because the statistical analyses are based on small samples and because insufficient data were available for adequate comparisons between the community based and residential services. Subsequent analyses will fill in the portrait sketched above, especially with respect to changes in the children's competency and family relationships. Most importantly, between group comparisons will answer questions about the relative improvement of the North Idaho CASSP children receiving intensive community based services, about their relative improvement in family functioning, and about their relative level of satisfaction with these services.

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Controlling Expenditures in Targeted Out-of-Home Placements: Findings from the California AB377 Evaluation Project

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The California AB377 Evaluation Project was established to study the replication of an innovative system of care in three California counties for youth suffering from severe emotional disturbance. Development of the innovative system of care was pioneered in Ventura County, California, and the replications were legislatively enabled through Assembly Bill 377 (AB377). This paper reports evaluative findings about a central goal of the innovative care system: the reduction of use of restrictive out-of-home placements through creation and maintenance of coordinated and effective community-based services. The results indicate that, for all targeted placement options, the demonstration counties have generated lower per capita, inflation adjusted, rates of expenditures than California as a whole. The evaluation results provide evidence that an integrated system of care can control targeted out-of-home expenditures. The nature, quality and effectiveness of any and/or all alternative services provided remains a topic for further investigation.

Introduction

Several recent national commissions have concluded that children and adolescents with severe emotional disturbance are critically under-served or inappropriately served within more restrictive settings than necessary (Joint Commission on the Mental Health of Children, 1970; President's Commission on Mental Health, 1978; Institute of Medicine (IOM), 1989; and National Advisory Mental Health Council, 1991). Empirical studies have documented the increasing numbers of youth placed out-of-home (Kiesler & Sibulkin, 1984; Kiesler & Sibulkin, 1987; Kiesler & Simpkins, 1991a). When a variety of inpatient care settings (including residential treatment centers, multi-service mental health organizations, general hospitals, psychiatric services, chemical dependency units and scatter beds) are considered in an aggregate summary, a troubling nationwide increase in the inpatient care of children and adolescents becomes evident (Kiesler & Simpkins, 1991a; Kiesler & Simpkins 1991b; Kiesler, Simpkins, & Morton, 1989). As an example, Kiesler and Simpkins (1991b) calculated an *87% increase* in the number of inpatient episodes for youth (246,929 to 460,671) between 1980 and 1985.

In part as a response to such findings from national commissions and subsequent research efforts, attempts at improving care for youth and adolescents have occurred at federal and local levels. As one example of Federal intervention, the National Institute of Mental Health (NIMH) developed the

Child and Adolescent Service System Program (CASSP), designed to provide assistance to states and communities in the development of comprehensive, coordinated systems of care for children and adolescents (Day & Roberts, 1991; National Institute of Mental Health, 1983). A central goal of efforts such as CASSP includes improving the quality, continuity and coordination of community services so that unnecessary and inappropriate out-of-home placements can be avoided.

The goal of reducing inappropriate out-of-home placements through integrated, coordinated and effective community care has been put to the test by the innovative system of care service demonstrations for youth now being replicated in California (for descriptions see Attkisson, Dresser, & Rosenblatt, 1991; Attkisson, Dresser, & Rosenblatt, in press; Feltman & Essex, 1989; Jordan & Hernandez, 1990; Rosenblatt & Attkisson, 1992). Development of the innovative system of care was pioneered in Ventura County, California, and the replications were legislatively enabled through Assembly Bill 377 (AB377). The three counties implementing the care system (San Mateo, Santa Cruz, and Riverside) are collectively referred to as the "AB377 counties." The California AB377 Evaluation Project, from which the findings in this paper derive, was established to study these replications of the Ventura model in California (more detail on the evaluation is provided in Rosenblatt & Attkisson, 1992; Rosenblatt, Attkisson & Fernandez, 1992; and Rosenblatt & Attkisson, 1993).

In California, the most important publicly-funded out-of-home placements for youth with severe emotional disturbance include: The State Hospitals, Group Homes, Foster Family Homes, Special Education Residential Placements, Probation camps, and California Youth Authority incarceration. Group homes, 3632 residential and state hospital placements were targeted for reductions in placements by the counties implementing the systems of care because they represent the most restrictive out-of-home placement options that are amenable to mental health intervention. Juvenile justice incarceration is subject largely to sentencing decisions made by judges. In fiscal year 1988/1989 group home, AB3632 residential, state hospital, and foster home placements amounted to 598 million dollars in expenditures, reflecting 82% of the State of California's public out-of-home care expenditures for youth (Ten Reasons to Invest in the Families of California, 1990). This section focuses on an evaluation of the efforts in the AB377 counties to reduce and avoid unnecessary placements of children and adolescents in Group Homes, State Hospitals, Foster Family Homes, and Special Education Residential placements.

Group Homes

A recent publication summarizes the importance of group home placements and expenditures in the State of California (*Ten Reasons to Invest in the Families of California*, 1990). First, in fiscal year 1988-89, more dollars were spent on group home placements than on any other out-of-home placement option ($347 million). These funds amounted to almost half of the $728 million spent on out-of-home placements in California. Furthermore, group home expenditures are rising at an alarming rate when viewed at the state-wide aggregate cost level, reaching $486,500,000 per year in 1991 (See Figure 1).

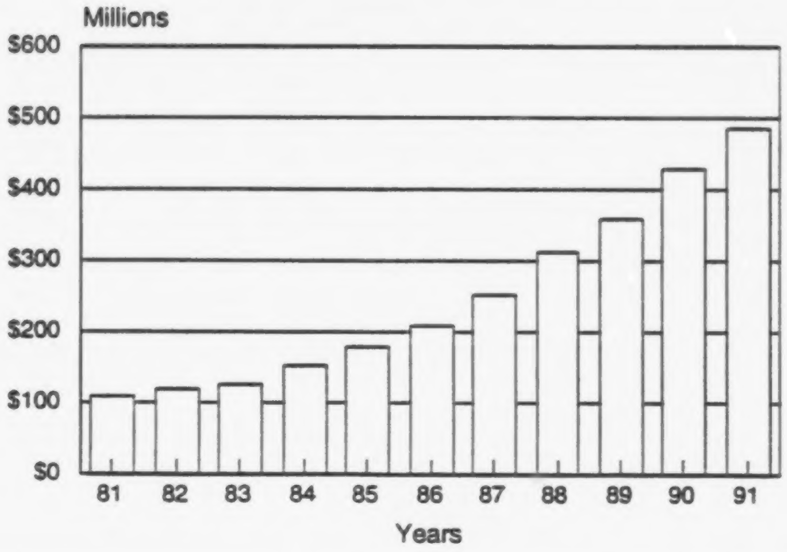
Group home facilities themselves vary tremendously, from those relatively small in size (4-10 beds) to 100+ bed structures that physically resemble psychiatric hospitals. A group home is defined by the California Department of Social Services as "a non-secure, privately operated residential home of any capacity, including a private child care institution, that provides services in a group setting to children in need of care and supervision, and which is licensed as a community care facility by the department."

Surprisingly little is known about the youth who reside in these homes. Youth are placed in group homes either because they have committed juvenile offenses and are wards of the court, or because of parental neglect, incapacity, absence, or abuse. In 1987, 70% of the youth placed in group homes resided in either the "psychiatric" or the "psychological" homes designed to provide some type of mental health services. Furthermore, "psychiatric" and "psychological" types of homes constituted 89% of the *newly* licensed programs in 1987. Finally, it was estimated that *only 10%* of all children in group homes receive services from local departments of mental health. The group home program in California, in essence, represents a de facto mental health structure outside of the formal mental health apparatus.

State Hospitals, Foster Family Homes, and Special Education Residential Placements

The State Hospitals represent a highly restrictive and institutional level of care whereas foster family homes represent a substantially less traditional and restrictive level of care. In many regards, these two types of residential treatment options could not be more different. The two California State Hospital facilities are administered by the California Department of Mental Health. They are large, highly institutional settings designed to treat youth suffering from the most severe and disruptive disorders. Although one facility is located in northern California and the other in southern California, youth often have to travel significant distances away from their natural home in order to be placed in these facilities. Foster family homes, on the other hand, are administered through the California Department of Social Services. In fact, unlike the state hospital, youth do not need to be suffering from a clinically diagnosed mental disorder to be eligible for placement in foster homes. Most typically, children are placed in foster homes after being removed from the original home for reasons of abuse and neglect (Landsverk, et al, 1992). Foster homes are located through-out the state and are quite small in size.

Figure 1
AFDC-FC Group Home Expenditures
The State of California



Finally, many local mental health departments place youth who are designated Severely Emotionally Disturbed (SED) by the schools into residential settings that are most often administered through the department of social services (e.g. group homes and foster family homes). These youth are identified and referred by departments of education and are placed with department of mental health funds and resources into social services administered facilities. Such placements are commonly referred to as "AB3632 residential placements" after the state legislative act, Assembly Bill 3632, that requires blending of funding among child-serving agencies for the provision of mental health and residential services to children who are designated by the schools as SED.

A brief set of statistics illustrate the differences between these three types of treatment options (Ten Reasons to Invest in the Families of California, 1990). In fiscal year 1988/1989, 38,600 children were placed in foster family homes, 500 children were placed through AB3632, and 300 children were placed in the state hospitals. The average cost per child per year was only $5,300 for a youth in foster family homes compared to $31,800 for a youth placed through AB3632 and $106,200 for a child per year in the state hospital. There are two state hospital facilities for youth in California and, in 1989, there were 18,019 licensed foster family homes (we do not have data on the number of foster care settings serving youth placed through AB3632). Finally, in fiscal year 1988/1989, $206 million dollars were spent on foster family homes, $16 million dollars were spent on AB3632 residential placements and $29 million were spent on state hospital placements for youth.

Public Sector Out-Of-Home Expenditures In The AB377 Counties

Data Sources

The data presented below for group home and foster home expenditures represent funds expended through the Aid for Families and Dependent Children-Foster Care (AFDC-FC) program and are provided by the California Department of Social Services. The amounts currently available for analysis reflect only these expenditures and therefore are not inclusive of total group home expenditures. We estimate, however, that approximately 90% of public expenditures for group home placements are now captured by our analyses. The largest proportion of non-captured public expenditures resides in expenditure contributions made through the mental health sector where we now know that approximately 7% of the children in group homes receive supplemental funding through a mental health "patch."

Method

The statistical analysis of group home and foster home expenditures is being conducted as a multiple time series design (Cook & Campbell, 1979). Expenditure and placement data are reported at the aggregate county level on a monthly basis. The data are for all youth placed in group homes in each study county. The data we present encompass 10 years of cost and placement episodes. In order to compare study counties with each other and with the state, the county expenditures and the state expenditures are adjusted for the population in order to yield per capita information. Therefore, the comparison data are converted to per capita amounts. The per capita expenditures are calculated by dividing the expenditures in each county by the number of youth in each county (defined as persons under 18 years of age). The same calculation is performed for the State of California as a whole, by dividing the total expenditures for California by the number of youth in the state. The raw data are then divided by the under-age-18 population for each fiscal year (1990 census projections) in each county to yield per capita amounts. An identical calculation is followed for AB3632 residential placements, except that the expenditure rates are calculated per 10,000 youth. This per 10,000 rate is used because the expenditures for AB3632 residential placements is relatively small and this lower ratio enhances clarity in presentation of the data. The expenditure data are also adjusted for inflation using the monthly regional (northern California for San Mateo and Santa Cruz; southern California for Riverside) and California (for the statewide expenditures) all-urban consumer price indices (with a base year of 1983).

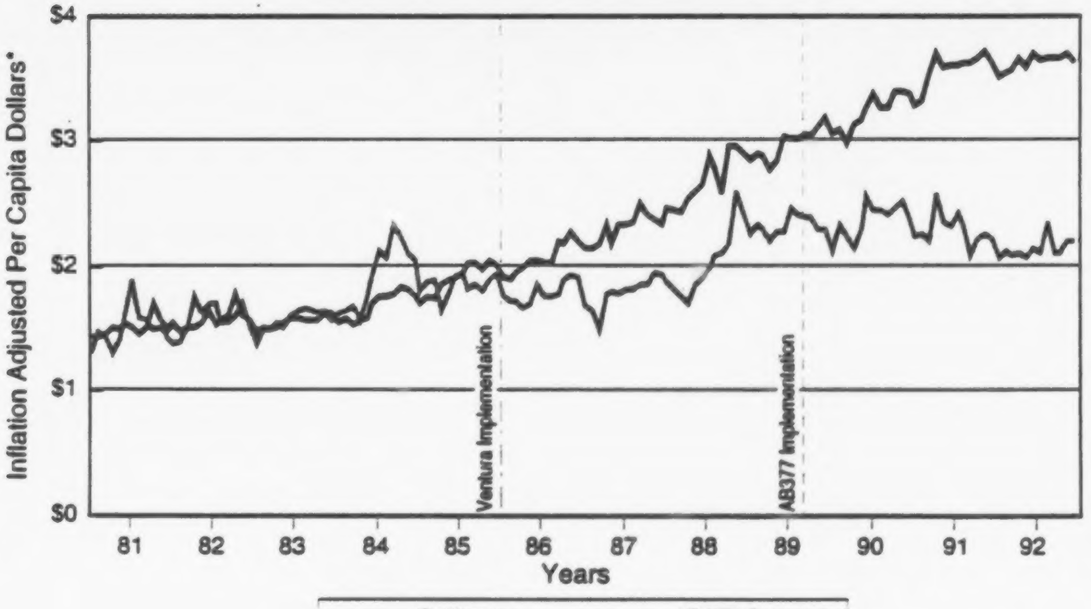
Adjusting the expenditure values for the rate of inflation allows a more accurate comparison of costs over time by eliminating fluctuations in expenditures that would correspond solely to changes in the overall price of consumer goods and services.

Results

Group Home Expenditures Across The Three AB377 Counties

The AFDC-FC per capita inflation adjusted expenditures for the three AB377 counties in aggregate were analyzed by comparing them to the AFDC-FC per capita inflation adjusted expenditures for the total State of California. The use of California as a comparison provides a baseline against which to judge progress of the AB377 counties in achieving programmatic and cost-saving goals. When these comparisons are made, the AB377 system of care counties, taken together, have lower per capita expenditures and a lower rate of increase in per capita cost over time than the state aggregate per capita expenditures. Figure 2 illustrates these trends in inflation adjusted dollars. Figure 2 indicates that the combined expenditures per capita of all the AB377 counties ($2.19 per capita inflation adjusted, $3.15 actual, as of June, 1992) is lower than the combined expenditures per capita for the total State of

Figure 2
AFDC-FC Group Home Expenditures
State of California & Combined AB377 Counties



* based on the CPI, populations under 18

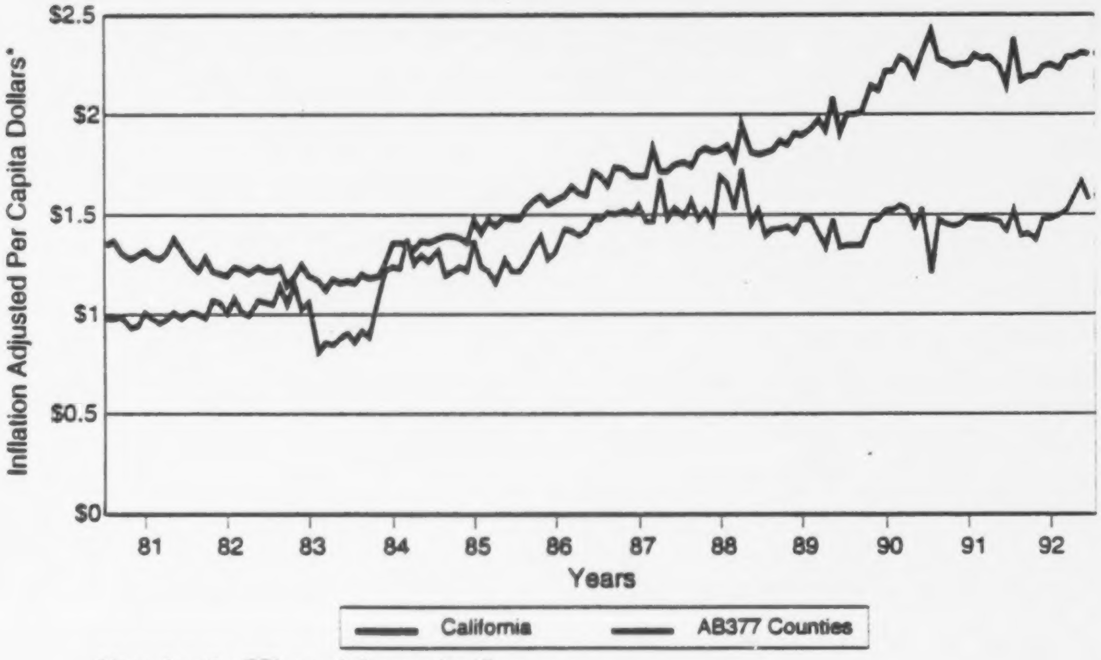
California (at $3.62 inflation adjusted, $5.25 actual, as of June, 1992). Figure 2 illustrates that the group home per capita expenditures for the AB377 Counties and the state were roughly the same until the middle of 1986. July, 1986 is approximately one year after the Ventura demonstration project began. There is substantial external evidence to demonstrate that the AB377 counties had already begun to implement the system of care modeled in Ventura county by the middle of 1986.

Foster Family Homes Expenditures

In general, the AB377 counties have not focused on reducing foster family home expenditures or placements. These placements are considered preferable to those made in group homes because of the less restrictive, more family-like environment. In fact, the AB377 counties are attempting to enrich and bolster existing foster family homes so that youth can be maintained in these home-like settings rather than moving to group homes. We therefore began our analysis of foster family home expenditures expecting to find increases in foster family home utilization and/or expenditures.

Contrary to this expectation, a comparison of the per-capita, inflation adjusted foster home expenditures for all three counties combined and each county separately to those for the State of California reveals that the rates are not

Figure 3
AFDC-FC Foster Home Expenditures
State of California & Combined AB377 Counties



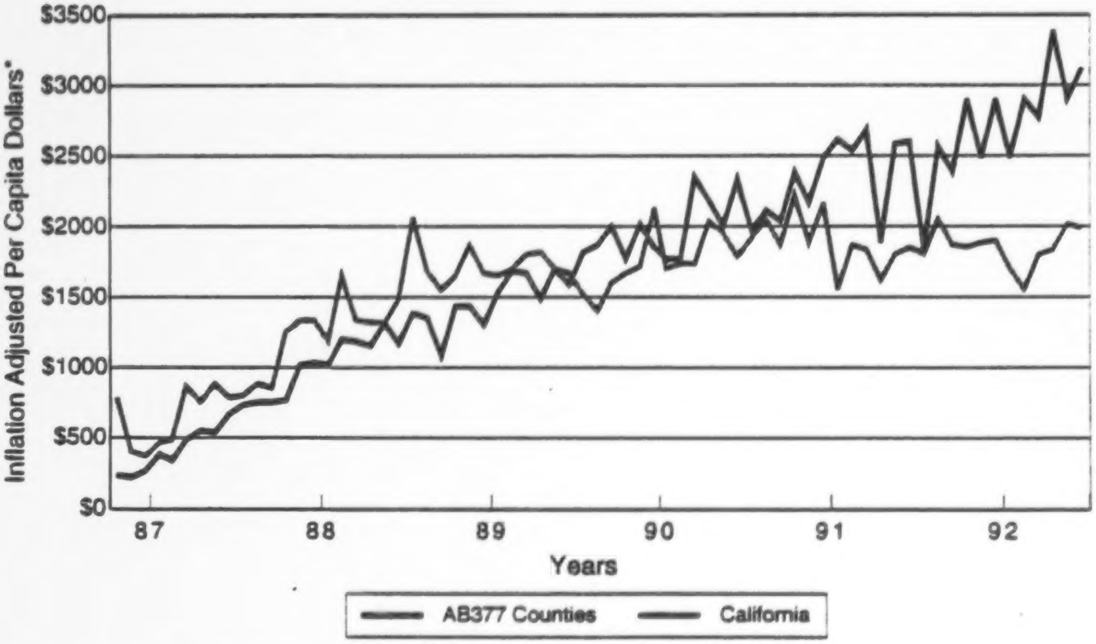
* based on the CPI, populations under 18

increasing in any of the counties. Taken together, the aggregate foster home placement data for all three AB377 counties (figure 3) indicate a relatively level pattern of expenditures since the first several months of 1989. In fact, until approximately August of 1988, foster home expenditures for all three counties, in aggregate, mirrored the expenditures for the State of California. At that point the expenditures for the AB377 counties began to deviate to a lower level than the state rate of expenditures. In June, of 1992, the inflation adjusted rate was \$2.30 per capita for the State of California and \$1.57 (in 1983 dollars) per capita for the AB377 counties in aggregate.

Special Education Residential Expenditures

The AB3632 programs did not begin until late 1986 and the expenditure data from these programs began to be collected soon thereafter. The data are presented graphically in Figure 4. These expenditures were obtained from records kept by the California Department of Social Services. They are reported on a monthly basis at an aggregate level from individual counties to the state. As the graphs indicate, the expenditures periodically soar dramatically. This is an artifact of supplemental expenditures that are added to the reports to account for youth not previously reported. Further, not all of California's

Figure 4
AB3632 Special Education Residential Expenditures
State of California & Combined AB377 Counties



* based on the CPI, per 10K populations < 18

58 counties place youth through AB3632 funds. As a result, the comparisons are really to the other counties that place youth through these funds rather than the state as a whole. As Figure 4 demonstrates, AB3632 expenditures for the study counties have remained level since the latter part of 1989. The state rate of expenditures, on the other hand, has increased steadily over the same time frame.

State Hospital Utilization and Expenditures

Since we do not currently have data prior to 1990 available for analysis, we cannot report longer term trends in State Hospital utilization. However, we can present the comparisons for the AB377 counties and the state rates of hospitalization for the 1990 calendar year. These data demonstrate that taken together, the AB377 counties are utilizing the state hospital at a lower per capita rate than the State of California. Furthermore, one county (Santa Cruz) did not use the state hospital at all during the 1990 calendar year.

In 1990, both San Mateo and Riverside each placed 9 youth in the state hospital. Although the numbers of youth placed in both San Mateo and Riverside were low, the charges per youth could be extremely high. For example, in Riverside the bed charges alone for the most expensive individual child over the course of a year were $142,665. When the $5,330 in ancillary charges are added the total charges for this one individual amounted to $147,995. Similarly, in San Mateo the bed charges for the most costly child ran $125,995 over the course of a year with ancillary charges at $1,634 for total charges of $127,629. The range in Riverside for State Hospital charges was $2,437 to $142,665 with a mean of $45,281.73. The range in San Mateo for State Hospital charges was $3,314 to $125,995, with a mean of $69,238.98.

We attempted to reflect state hospital utilization from the 1990 data by comparing the per-capita charges in the AB377 counties with the per-capita charges in the State of California. According to the 1990 census, 6.8% of the youth in California reside in the three AB377 counties, consequently we would expect 6.8% of the $31,338,496 in total California charges ($2,144,826) to be reflected in these three counties. However, the total charges for the AB377 counties is about half this amount, at $1,030,687 in calendar year 1990.

The numbers of youth and overall charges for state hospital placements for the AB377 counties both seem to be below what would be expected given their populations. In general, the numbers remain relatively small (with no youth being placed in Santa Cruz); and do not seem to indicate that significant numbers of youth diverted from other placements are residing in the state hospital facilities. The analysis of charge and placement trends over time will be necessary to further understand patterns of hospitalization in the AB377 counties.

Discussion

As we mentioned earlier, AFDC-FC group home expenditures in California approached half a billion dollars in 1990. The AB377 counties are showing lower per capita group home expenditure and placement rates than the State of California. A more detailed analysis of each individual county (see Rosenblatt, Attkisson, & Fernandez, 1992 and Rosenblatt & Attkisson, 1993) reveals that historically, two of the counties, San Mateo and Santa Cruz, were above the State rate in expenditures and utilization for five years or more before dropping below the state rates. Riverside was approaching the California rate until the beginning of 1989, when the rate of group home expenditure and placement growth in the county slowed and eventually began to decrease.

Although these are all encouraging findings, more research is required before we have the maximum confidence possible that the service system interventions are successful both in reducing out-of-home expenditures and utilization *and* in providing necessary and effective community-based alternative services that result in higher quality long-term clinical and social functioning outcomes.

With respect to reducing group home expenditures and placements, our use of a multiple time series design can provide good evidence of causality relative to other quasi-experimental designs (Cook & Campbell, 1979). Future research and reports will require analytic techniques for examining gradual implementations of programs in series over time (Cook & Campbell, 1979; McCleary & Hay, 1980) in order to achieve the best possible confidence in understanding our findings. Assessing which components of the system are producing the observed results, which are not, and which are a matter of fortune also remains an important question for future investigation. It must be further underscored that this paper presents expenditure data. Expenditures are based on rates and charges and are not the same as "costs." The demands of legislative action, the expense of collecting actual *cost* data, and the need for ongoing monitoring will likely make expenditure and charge data the central performance indicators for any counties within California that attempt to implement systems of care for SED youth.

The work presented here is only one component of a program of evaluation and services research designed to assess the effectiveness of an innovative system of care for youth in California. The administrative, policy-oriented evaluation and secondary data analyses being conducted as part of the California AB377 Evaluation Project will be supplemented by a grant funded by the National Institute of Mental Health (NIMH) that will allow for original data collection on client outcomes and costs to provide an overview of the success of these counties (for a more detailed description, see Attkisson, Dresser & Rosenblatt, 1991, 1993 In Press; & Attkisson, Rosenblatt, & Dresser, this volume). Few other such comprehensive efforts exist, with the most notable exceptions being the evaluation of the Fort Bragg project in North Carolina (Bickman, Heflinger and Pion, 1990); and the Robert Wood Johnson Foundation's Mental Health Initiative for Youth being conducted in several sites nationwide (Beachler, 1990; Saxe, 1991).

Perhaps we can now provide one key answer to the first of many questions posed by our program of research: Across three different sites, county level systems of care can manage and control escalating expenditures and placements in specifically targeted restrictive levels of care. The questions that remain, however, are at least equally challenging. Nonetheless, it is absolutely clear that at least in California, programs must demonstrate fiscal accountability in order to survive. Such enhanced accountability for public systems of care is essential if other efforts are to succeed nationwide.

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Children's Service Delivery in Rural West Virginia: Measuring System Changes and Restrictiveness of Living Environment

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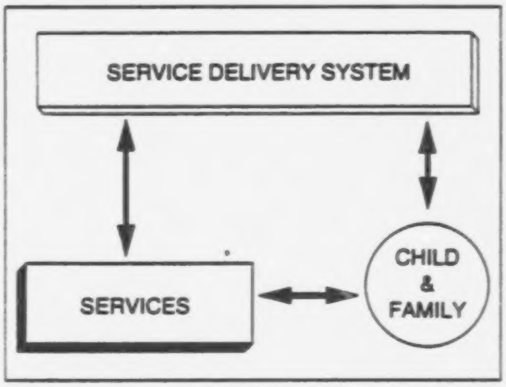
This study tracks the impact of policy and decision making changes over the past three years in rural West Virginia. In a limited number of communities, the state has recently implemented a system of care approach to treating individual children and families. Two communities which have implemented systemic changes are compared to control communities on several child outcome measures. These measures include living environment, cost of services, and contacts with juvenile justice system. This paper covers preliminary data on living environment. Results show that the system of care approach to service delivery reduces average number of placements, places children in less restrictive living environments, and reduces the total number of out-of-state placements.

Background

In an effort to develop community level integrated service delivery systems which would provide services to the state's multi-need children and families, the state of West Virginia has implemented several policy and decision making changes over the past 3 years. To achieve an integrated system, the state recognized certain ongoing problems and attempted to rectify them by focusing on the following goals: reducing out-of-state residential placements, developing a range of services, reducing system fragmentation, reducing out-of-home care, improving the quality of services, and providing professional training and technical assistance. Simultaneous to the climatic changes occurring in the state, the National Institute of Mental Health awarded the West Virginia Office of Behavioral Health Services a research demonstration grant to evaluate the impact of different service delivery system models on individual children and their families. The research application proposed a systems level intervention or community wide changes in service delivery (Zeigler-Dendy, 1990). The research design utilizes a macro-level system approach and investigates the impact of different delivery systems on individual children and families. As shown in Figure 1, it was theorized that the service delivery system of a community effected individual child outcomes, independent of, or in interaction with, individual program or treatment effects. It was hypothesized that children who reside in

Figure 1



communities which have an integrated system will be more positively effected on a number of outcome measures than those children residing in communities with a more traditional system.

As an investigation of this hypothesis, the West Virginia Research Demonstration grant is a longitudinal study measuring indicators of system and individual client outcomes in 8 communities over a 2-year period. System wide interventions were implemented in 2 of the 8 communities under study. These two communities, referred to as Model A sites, are compared to moderately changed communities (Model B), and, also, to a third group of communities where no service delivery system changes have been made (Model C). The three types of Model communities are compared on the child outcome measures of restrictiveness of living environment, cost of services, and contacts with the juvenile justice system. The systemic interventions implemented in the two Model A communities are described below.

Interagency Planning and Placement Committees (IPPC)

Interagency Planning and Placement Committees (IPPCs) are multiagency decision-making teams which serve dual purposes. IPPCs were initiated as an effort to return youth with severe emotional disturbance who were placed in unnecessarily restrictive programs to their communities. The teams serve as gatekeeping mechanisms to prevent unnecessarily restrictive placements in-state and out-of-state. The teams are composed of multiagency representatives and develop individualized treatment plans which are client and family focused.

Flexible Funding

In 1991, the state issued a funding policy giving IPPCs the use of flexible funding. This policy created the mechanism to divert state dollars currently being spent on out-of-state residential care into community based service plans for IPPC children and their families. It helps to prevent out-of-state and out-of-home placements by empowering IPPCs to develop wraparound plans and services which may not exceed the cost that would have (or had) been spent on out-of-community residential care.

In addition to the support provided by the state policy, the two treatment sites were given an additional annual flexible budget of $5,000 to be used at the discretion of the IPPCs. These flexible funds are spent on items or services for children when no other source of funding is available. Typically, funds are used on such purchases as baseball game tickets, pizza, birthday gifts, and payment for peers to serve as friends.

Intensive Case Management

The state has long recognized the need for more intensive case management services for children with severe emotional disturbance and their families. In 1990, a pilot project was initiated at the treatment sites to make available intensive case management services to IPPCs[1]. Intensive case management positions were initially funded by the state and then became self supporting throughout Medicaid reimbursement.

The model of case management has several key components which were new to the state. These components included: restricted caseload of 8 to 10 families, 24 hour availability, and flexible work hours. Intensive Case Managers obtain initial referrals through local IPPCs only, access flexible funding, and provide in-home services. Case management services are directed toward entire families and the services operationalize commitments to family focused care. Previous to the intensive case management model, the state utilized a lead agency case management approach, where the referring agency was responsible for coordination of services for the child and family.

System Managers

Perhaps the strongest intervention employed in the development of local system building has been the position of System Manager. A System Manager has the responsibility of identifying barriers to and strengths of implementing a local system of care. System Managers serve as a hub for the local community network of providers and administrators. Specific work duties include training case managers, facilitating and initiating IPPC meetings, reporting confidentiality practices and case evaluation process, and initiating and running community system planning efforts.

System Managers receive monthly training and supervision from the state level coordinator[2]. Currently, there are 9 System Managers throughout the state who serve 20 counties. Unfortunately, only one of the Model A communities has employed a System Manger for the full duration of the study. The other county employed a System Manager until December of 1992, thus prematurely ending this intervention approximately 1 year and 4 months prior to the ending of the study.

System Assessment

System assessments have been performed in the Model A communities as a manipulation check of the intervention. System assessment also allows for training and technical assistance to be tailored to the needs of each community. Assessments were completed in both years of the project, 1991 and 1992. For both years of the assessment, expert reviewers evaluated both Model A communities and an additional 3 communities. At each site, reviewers examine community documents, examine a grid of available services and a community plan for service development, and interview key community stakeholders. After data collection, each reviewer independently completes a systems measure (Rugs, Friedman, Zeigler-Dendy and Warner, 1991). Finally, both reviewers collaborate on a condensed list of strengths and weaknesses specific to that site. For a full review of the procedure, see Rugs, Lazear, and Kutash (1992). The assessment results include category scores for each site computed as a percentage of the total possible score for all valid items in that category. In addition to producing scale scores, points of consistency referred to as areas of strengths and weakness are given. Based upon these results, specified technical assistance is provided on community service needs. The results of the reviews indicate that both Model A communities have made great strides toward the development of a system of care for children and their families[3].

Notes:

[1] Training and consultation for thecase management pilot project was provided by Chris Zeigler-Dendy.

[2] The authors wish to acknowledge the work of Beth Morrison. Beth is the state coordinator of IPPCs and Systems Managers.

[3] The results of the 1991 and 1992 assessments are available from the first author.

Evaluation

Overview

This study utilizes a three level mixed analysis of variance model, with service system model type (A, B, or C) as a between subjects factor and time (the months of March and September of 1992) as a within subjects factor. The components which differentiate these model types are listed in Table 1. To select sites, all 55 state counties were categorized by model type and counties within each of the 3 types were randomly selected for inclusion in the study.

Subjects

The target population chosen for study were children between the ages of 5 and 17, who were in the custody of the state Department of Health and Human Resources (DHHR). One hundred seventy six children and adolescents have been included in the subject pool for the study (104 males and 72 females). In each of the counties chosen to serve as either an A, B, or C Model type, all eligible children were included as subjects. Sixty nine subjects were included from the two Model A counties, 55 subjects from the three Model B counties, and 52 subjects were included from the three Model C counties. The subjects were Caucasian, with the exception of 5 African-American and 6 bi-racial youths. At the time of initial data collection (March 1992) the average age of the subjects was 14.

Dependent Measures

The study data are being collected from three categories of measures: subject outcomes, family measures, and child welfare record reviews. For brevity, only the child outcome measure of restrictiveness of living environment and frequency of placements are presented.

As of this writing, outcome data on subjects restrictiveness of living environment have been collected for the months of March 1992 and September of 1992. The restrictiveness of living environment (RLE) score is calculated separately for each month. To calculate the score, a Children's Restrictiveness of Living Environments scale was used (Thomlinson & Krysik, 1991). Thomlinson's Scale is an expanded version of work by Hawkins (Hawkins, Almeida, Rabry, & Reitz, 1990). The scale was developed by asking experts in the children's mental health field to rate the restrictiveness of a list of environments on a scale of 1 (least) to 7 (most). The range of living environments range from 1.51, a self maintained residence to 6.58, a secure treatment facility.

For each subject, a total RLE score for one month is computed by multiplying the number of days spent at a placement type by the restrictiveness score for that placement. This is done for as many placements as the child lived in for the month

Table 1
Service System Models

Model A	Model B	Model C
Preston/Mercer	Mineral/Mon/Wetzel	Jackson/Lincoln/Wayne
IPPC	IPPC	No Inter-agency Tx Planning Teams
Flexible Funding $5,000 Additional	Flexible Funding	Traditionally Funded System
Intensive Case Management	Lead Agency Case Management	
System Supports System Assessment System Managers Training Technical Assistance		

and summed for all placements. The total score is then divided by the number of days in the month, for the average RLE score (31 days for March and 30 for September).

Results

In March of 1992 average RLE scores ranged from 2.40 to 6.40 and, for all subjects, the average daily RLE score was 3.66. In September, average RLE scores ranged from 2.40 and 6.58 and, for all subjects, the average daily RLE score was 3.45. See Table 2 for average RLE scores by Model type.

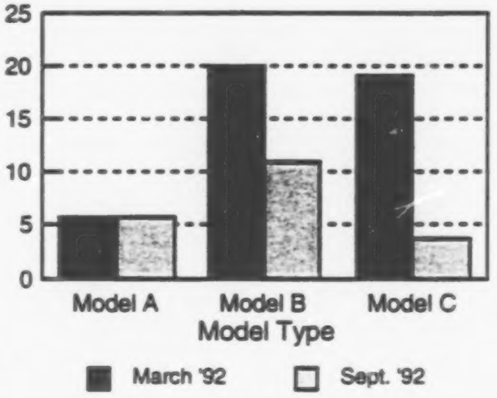
Table 2
Average RLE Scores by Model Type for Wave 1 and 2 (*n* = 170)

	Model A	Model B	Model C
March 1992	3.64	3.76	3.61
September 1992	3.38	3.46	3.67

An analysis of variance was performed on the first two waves of data on the average RLE score for 170 subjects. Only the effect for time was significant, $F(1,167) = 6.39$, $p < .05$. Model type did not significantly predict RLE scores.

RLE trends for other related measures appear to be in the predicted direction. The frequency of multiple placements for the month of March is lower in Model A sites than in Model B or C sites, see Figure 2. The vast majority of children in Model A sites resided in only one living arrangement during the months of March and September, and for most this was the same placement. Additionally, reported out-of-state placements, from January to June of 1992, were lower for Model A sites than Model B or C sites. Model A sites reported 1 out-of-state placement, while B sites reported 5 out-of-state placements, and C sites 10 out-of-state placements.

Figure 2
% of Cases with Multiple Placements



Overall, when taking a closer look at where children were placed in March and in September, it is clear that Model A sites used Treatment Foster Care as a first resort considerably more often than did Model B or C sites (see Table 3). Also, children in C sites, and especially B sites were placed in secure facilities more often than children in A sites (see Table 3). In general, more children were living at home during September than in March. While this may be encouraging, the authors caution the reader that it is not known whether these children returning home have adequate mental health services or protective services.

Summary

The above results cover two waves of outcome data on restrictiveness of living environment. Although the ANOVA for RLE was not found to be significant for Model type it is important to note that two more waves of data will be forthcoming. The initial data were collected after an eight month start up period for Model A sites. It is understandable that the experimental site,

Table 3
Frequency of Subjects' Living Environment for March and September 1992

1st Placement	Model A		Model B		Model C	
	March	Sept	March	Sept	March	Sept
self-maintained residence						
private boarding home						
home of child's friend						
home of family friend						
home of relative			2	3	3	4
home of biological parent	4	12	2	7	5	6
homeless/runaway	2				1	1
adoptive home				1		
supervised independent living	1	2				
independent living group home						
regular foster care	11	13	18	20	15	13
family emergency shelter						
receiving foster care						
treatment foster care	30 (43%)	26	6(11%)	2	5(10%)	5
special needs foster care	1	3	1	1	2	2
long-term group home	11	5	11	9	9	8
emergency shelter	1		3	1	2	1
receiving group home						
medical hospital						
private residential school						
wilderness camp					2	2
ranch-based treatment center						
open youth correction facility						
adolescent drug/alcohol rehab						
cottage-based group home	2		1	2	4	2
psychiatric group home			3	3		3
youth drug/alcohol rehab		1	1			1
Armed Services base						
Young offender group home	2	4	3	3		
psychiatric ward/hospital						
psychiatric institution	2		1	1		
closed youth correction facility	1		2	1	3	1
adult correction facility						
secure treatment facility	1		1		1	1
number of subjects	69	66	55	53	51	51

Model A, will be more experienced at operationalizing the system of care values by the fourth wave of data. Even so, initial data show trends in the expected direction. Overall, Model A sites did better at reducing the restrictiveness of placements. Perhaps more importantly, Model A sites made a conscious effort to provide stable placements and were successful in their efforts.

The above results provide evidence that changing the way services are delivered by changing the way decisions are made about children and families does indeed impact individual children and families. It is a long held belief that it takes a considerable amount of time (years) for policy and systemic changes to effect individual children. The current study provides direct evidence that system effects might be more potent than was first assumed. However, this type of research is new and unfamiliar and, at best, the causal line between system changes and individual outcomes wavers. Future research on systemic reforms is needed which more closely examines the relationship between system reforms and growth and access of services.

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The Robert Wood Johnson Family Mosaic Project: Evaluation, Challenges, and Future Directions

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The San Francisco Family Mosaic Project is one of eight national demonstration sites funded by the Robert Wood Johnson Foundation Initiative, Mental Health Service Program for Youth, to provide mental health services to children and adolescents with serious emotional disorder (SED). The awards were made directly to the states to foster state and local agency collaboration. In California, the State Department of Mental Health has contracted with the San Francisco Department of Public Health to administer the grant. The Family Mosaic Project is in its third year of service provision. Its goals are to develop the necessary financing that will enable the organization to provide individualized services in as normal, and least restrictive an environment as is possible. One hundred and seventy-five children and youth have been served by the project to date. The majority of the youth are between the ages of 6 and 16, disproportionately African American males, and enrolled in special education. As the project prepares for continued service provision it is continuing to address several challenges identified over the previous three years. The challenges which are currently facing the project include, human resources, systems, finances, leadership, service development, information technology and research and evaluation.

The Robert Wood Johnson Initiative

The Robert Wood Johnson (RWJ) Initiative entitled the *Mental Health Services Program for Youth* is a national service system demonstration exploring innovative ways to address the human service needs of children with serious emotional disorder. Beginning in 1988 the Foundation committed over 20 million dollars over five years to eight sites to support the development of community-based systems of care. The eight sites are located in Pennsylvania, Wisconsin, Ohio, Oregon, Kentucky, Vermont, North Carolina and California. The RWJ Initiative required agreements between state and local agencies to sanction politically the systems of care, and to foster innovation in the financing of care.

Although each site differs programmatically and in the design of the actual implementation of the project, all sites share four common objectives[*]. The first objective is to establish *individualization of care in the least restrictive settings* such that the provision of services is specific to the needs and circumstances of individual children and their families. A second objective is to organize the *management of care* so that there is a decreased likelihood of lifetime dependency upon public services. The third objective of the initiative is to encourage *normalization of care* – RWJ sites provide services to children within the same environment that other children receive services (i.e., the home, school, and community). The final major objective of the Family Mosaic Project is to promote

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innovation in the *financing of care*. Each of the eight sites are seeking to expand the funding mechanisms available to children with serious emotional disorder in light of their complex array of human service needs. It is the goal of the Foundation to enable each county/state partnership to achieve continued funding for children's services beyond the grant period.

The Family Mosaic Project: Administration and Staffing

The San Francisco California site for the RWJ initiative is the Family Mosaic Project – a community based, multidisciplinary organization designed to deliver comprehensive care to youth suffering from serious emotional disorder (SED). The Family Mosaic Project is part of a larger state effort to implement a comprehensive system of care for youth with serious emotionally disturbances, known as the *California Comprehensive Children's Mental Health Model* (Rosenblatt & Attkisson, 1992; Rosenblatt & Attkisson, in press). The model system of care was first implemented in Ventura County California (Feltman & Essex, 1989; Jordan & Hernandez, 1990) and is now being replicated in the three additional counties of San Mateo, Santa Cruz, and Riverside. With RWJ, San Francisco joins the system of care counties in a coordinated effort to integrate the services provided to children with SED by five primary service sectors: mental health, public health, social services, juvenile justice, and education.

Foundation contracts were awarded directly to the state, and in California the project is managed by the State Department of Mental Health (DMH). The state DMH has contracted with the city and county of San Francisco through the Mayor's office of *Children, Youth & their Families* and the Department of Health to receive the RWJ award. The Family Mosaic Project is housed administratively within the Department of Public Health. In San Francisco, the Department of Public Health has been designated as the lead agency in the oversight of the project which represents each of the five agencies.

The Family Mosaic Project: Staffing

Case managers (referred to as "family advocates") are "in kind" staff contributions to the project from the Departments of Social Services, Juvenile Probation, Public Health, Community Mental Health, and the San Francisco Unified School District. The family advocates have master's level education, and reflect the disciplinary and organizational diversity, as well as the ethnic diversity of the city and target population. This interagency collaboration of staff has not been without challenge. Project leaders have had to resolve several important challenges including: (a) managing the impact of differing levels of staff skills; (b) providing for the implementation of effective training; (c) incorporating differing cultures and expectations of staff from these service sectors; (d) adapting to rapidly changing information technology and its impact on service delivery; (e) adapting to rapidly changing strategies for the organization and financing of human services including radical revision of the roles of government and the private sectors in the process; (f) establishing effective communication of program philosophy; and (g) carrying out innovation in a civil service environment.

Who Are the Children Being Served?

As of January 1993, 175 youth have been assigned for assessment. The largest proportion of children enrolled were African Americans with 106 (60.3%), while the remainder were 24 Caucasian (13.7%), 23 Latino (13.2%), 9 Asian/ Pacific Islander (5.2%), 1 Native American (0.7%) and 12 others (16.9%), including biracial youth. Males outnumber females 3 to 1 at 135 (77%) to 40 (23%). Fifty three (30.7%) of those enrolled are under 11 years of age, 34 (19.3%) are between 11 and 12 years old, and 88 (50%) are age 13 and above. Delinquent minors account for 24% of the sample and dependent minors represent 24.5%. Seventy four percent of the youth are enrolled in special education.

The majority of Family Mosaic clients live with their biological mother (97 or 55.6%), while the next most frequent residence is with a relative (34 or19.3%). Very often the relative is the grandmother of the child. The third most frequent residence of the children is with their biological parents (16 or 9.1%). To date, 61.4% of the children have DSM-IIIR diagnoses. They include 48 with affective disorders (27.4%), 31 with disruptive behavior disorders (17.7%), 9 with ADHD (5.2%), 9 with PTSD (5.2%), 7 with psychosis (4.1%), and 3 with anxiety (1.8%). Approximately one third of the children have been victims of documented abuse - physical, sexual, and/or neglect. Finally, 62 families have left the project, having withdrawn, moved, been placed in long term placements, or completed their involvement.

Preliminary Outcomes

Data are being gathered about the clients in three important areas - school attendance, school performance, and days of juvenile detention. The raw data suggest that improvements have occurred in each of the three areas when comparing the client's record prior to enrollment in the project and subsequent to their enrollment in the project. To date, however, only improvement in school attendance is statistically significant.

Challenges and Future Direction of the Project

The Family Mosaic Project has made important strides in the implementation of a system of care. As such, the human resource, leadership, systems change, fiscal, service development, information technology, and research and evaluation challenges facing it are ongoing and inevitable. A few of the areas are highlighted below.

Human Resource Challenges

There are many human resource challenges confronting the project including bridging the dual loyalties and organizational cultures of staff, explicating the evolving definition of case management, addressing staff training needs and procedural issues/complications, and managing the internship and residency trainee programs subsumed under the organization. Many of these issues have been addressed, while for others it will remain an ongoing concern of the organization.

Systems Change

As an innovative system of care demonstration project, Family Mosaic has met with tremendous difficulty in its attempts to undertake change. In none of the areas has this difficulty been more evident than in Family Mosaic's attempts at challenging the various child serving systems' standard order of business. Service provision has been fragmented, and community based organizations with which the Project has wanted to enter into contractual agreements have limited resources. There have been difficulties in the management of the intraagency collaboration upon which the Project was founded. This area, however, has also been one of the most significantly changed. For example, work group meetings have been re-instituted to support intraagency needs. But perhaps more importantly has been the realization that Family Mosaic principles (hence System of Care Principles) are being adopted by the larger San Francisco community.

Fiscal Management

The fiscal challenges facing the Project are numerous and include or have included exploring the possible financing options with the city and state such as expanded Medicaid (Medical) options, and the pooling of city and county funds to secure a larger federal match. More importantly for the Project has been the development of a "capitation" system for financing service provision that accurately reflects the clinical need of the children and fiscal realities of the system. A final challenge presented has been the continuous development of fiscal strategies and arrangements with community agencies that will allow for expanded service provision.

Service Development

Services that address the unique challenges facing children with severe emotional disorder must be developed. These services must allow for the same degree of normalization of care that children not suffering severe emotional disorder receive. This manner of thinking is new for many service providers. For Family Mosaic and the agencies with which it is contracting to provide services, this journey has been one fraught with reluctance and anxiety. In spite of this reluctance however, several "non traditional" services have been developed and include in-home conflict resolution, respite, shadows, mentors, and the utilization of pediatric primary care residents to provide general health assessment and treatment.

Research and Evaluation

The final challenge to be discussed examines the conduct of research and evaluation in a system of care. As a demonstration project Family Mosaic and the other Robert Wood Johnson funded sites must evaluate their projects, documenting the process and outcomes associated with a child's involvement in the project. A Paradox database application entitled *Caretrack* was developed as part of the plan to evaluate the projects. *Caretrack* is undergoing continuous modifications as a result of site identified revisions and programmer modifications. In tandem to the utilization of *Caretrack* as the evaluation tool, a separate information system database had to be created in order to address the immediate need for feedback and information on the status of the children involved in the project. Ideally, only one system is intended to be used. Furthermore, as one of its founding principles Family Mosaic has supported the conduct of research in applied settings. However, it has been much more difficult to put this ideal into practice. Although the agency is open to the idea of allowing its clients to be invited to participate in various research opportunities, it has been more difficult to develop research projects from within the agency. There has been reluctance for a variety of reasons including the belief that clients may be denied access to services, staff may be over burdened with additional responsibilities, and in some instances a questioning of the cultural relevance and appropriateness of research. Hence, the challenge continues to be one of managing successful research collaboration efforts.

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Two Models of Robert Wood Johnson Mental Health Services Program For Youth Projects Using Parents as Advocates in Pennsylvania and Wisconsin: Rationale, Strategies and Outcomes

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Parent Advocates under contract in Pennsylvania and Wisconsin provide an important component of the services offered families of children with serious emotional disorders in their respective Robert Wood Johnson Mental Health Services Program for Youth Project sites, both of which are participating in a national demonstration program to improve the delivery system of mental health services to youth.

Introduction

In 1990 the Robert Wood Johnson Foundation funded eight states to develop community-based systems of care for children with serious emotional disorders. This paper describes the programs in Delaware County, Pennsylvania, and Dane County, Wisconsin, which were chosen as two of the demonstration sites. Each site has active parent organizations that recognized the necessity of incorporating into the programs strategies to provide a variety of peer support services, including parent or family advocates for families served by those programs.

Wisconsin

Wisconsin's program is called Project FIND (Families in New Directions). Congruent with the Project FIND goal of deterring unnecessary out of home placements is a recognition of the need for an effort to enhance the caregiving capabilities of families. Included among the underlying principles behind the program is the belief that there must be ongoing empowerment of the family and its natural support systems. To reflect that belief, the work plan included among its tasks that of securing funding to support the involvement of Wisconsin Family Ties (WFT).

Wisconsin Family Ties is a statewide non-profit, parent-run organization established in 1987 to provide a variety of parent-to-parent support, education and advocacy services for families who have children and adolescents with serious emotional and mental disorders. In 1985, a Dane County parent support group was established, and parents who have children with serious emotional and mental disorders have had an increasingly strong advocacy presence in the county since then. In August 1992, a Family Ties Family Advocate position was funded by Project FIND, and a parent was hired to fill that position.

The Family Advocate provides individual peer support to parents who have children receiving services from the Project, provides them with information about childhood emotional disorders and the county service system, refers them to family support services available in the community, introduces them to the WFT Dane County support group and helps them network with other Project FIND parents.

The Family Advocate helps parents "navigate" the system, advocates for them with providers, schools and courts, and promotes their involvement in policymaking and advisory groups. Examples of advocacy include meeting with a father's case manager and therapist to discuss the status of the son's foster placement, attending a case management staffing with a mother to help set up a crisis plan for her son and attending a court hearing with a mother.

A "family ally" program has also been developed. This program identifies veteran parents who are trained to become allies or mentors to parents new to Project FIND. This greatly expands the scope of the support services WFT is able to provide for parents. To promote networking between Project FIND families, an informal get-together was scheduled. Both children and parents were invited and during the event children participated in activities organized and supervised by social service aides. The newly trained family allies were introduced. Wisconsin Family Ties' ability to serve these families is dependent on the support of Project FIND clinical case coordinators and crisis workers at the Mental Health Center of Dane County, who refer families. From the inception of this effort, it has been clear that both the managers of the Program and line staff recognize the value of the mutual support, guidance and practical services that can be provided to families by peers. They realize that an exclusive focus on formal services does not recognize that parents and other family members have service needs that are associated with the stresses of living with a child who has a severe emotional disorder. (Friesen and Koroloff, 1990) They recognize that peer support increases a family's ability to cope, decreases dependence on formal supports and fosters independence and mutual interdependence. Parents gain in the ability to control their lives and become involved in shaping their environments. (Weissbourd and Kagan, 1989)

Wisconsin Family Ties has long believed that professionals who view families as allies and work to help families to empower themselves ultimately make their jobs easier. Empowered parents will gradually gain in confidence and become influential in securing, coordinating and evaluating the services their child receives. In addition, parents who feel good about themselves in their roles as parents and who are satisfied with the services their family is receiving may become willing to reach out to other parents who are struggling. They also can become strong allies in the effort that is needed to advocate for continued improvement in the systems that deliver mental health services to all children and youth who need those services. Professionals realize that the public testimony and advocacy provided by parents is increasingly necessary for obtaining available resources.

With parent input, Project FIND developed a managed care system of finance that will pool funding for children receiving services from the Project. In this system, money will be paid out of this funding pool to support an individualized treatment plan for each child. The task of identifying the benefit package of services to be included was one of the tasks to be accomplished in the development of this model. WFT believes that the benefit package should include an array of services and supports for families which will enhance their coping skills and their ability to maintain their child in the home. There are concerns that many of the proposed services are very "child directed," that there is a strong emphasis on the "medical model" approach to service delivery, and that there is an inference that only services provided by a professional have real value. It has been suggested that the benefit package should include the following support services: self-help groups, ongoing individualized parent support, crisis intervention, and respite. Coping and skill development training should be available for parents, they should have access to disabilities information and be assisted with strategies for individual advocacy and systems change. They should have information about all the available resources in the system, receive direct assistance to assure that they receive all the services to which they have a right and be able to access case management or service coordination services.

WFT developed an evaluation instrument to assess parent satisfaction with support services received from Project FIND. This instrument also gave parents an opportunity to suggest improvement and additions. The evaluation identified parent support groups, peer advocacy with service providers or schools, crisis intervention, respite care, case management/coordination and parenting skills training as services that parents found the most valuable. Using the results of this evaluation, WFT plans to continue in its role as a valued partner in the effort to improve mental health service delivery to children, youth and families in Dane County.

Pennsylvania

With funding from the nation's largest health care philanthropic organization and in partnership with the Commonwealth of Pennsylvania, Delaware County embarked on an ambitious project to establish a comprehensive system of care for children with serious emotional problems and their families. This project, called Parent and Child Cooperative (PACC), provided enhanced comprehensive and coordinated services to children and their families. Significant steps were taken preparing for grant implementation during 1989-90, a planning year funded by the first grant award from the Robert Wood Johnson Foundation. Under the direction of the Delaware County Department of Human Resources and the Pennsylvania Department of Public Welfare, the planning process was completed with the involvement of county staff, providers and families.

When Pennsylvania selected Delaware County as its grant implementation site, Delaware County elected to develop a contract with the PIN (Parents Involved Network) organization to provide parent support and advocacy services specifically to families who would receive grant services. PIN is a parent-run, statewide network of parents, parent groups and others interested in children's mental health issues which cuts across all of the child-serving systems. PIN's mission is to address the unique needs of children and adolescents with emotional, behavioral or mental disorders by providing information, support and an advocacy voice for children and their families.

Interviews with the families who were receiving grant services were conducted to serve interrelated purposes. While the immediate purpose of collecting information for Delaware County was to ascertain customer satisfaction and make any changes needed to ensure a family friendly program, the larger purpose reflected a more global need.

Often times, lists have been developed describing the unmet needs of families. These lists have been generated nationally in a variety of professional arenas. All too often parent input is either not solicited or is discounted. It has also been stated that "parents don't know what they need". However, when these lists have been reviewed by families, they do not always agree. In some cases, families totally disagree with the findings. The interviewer that conducted this study is the parent coordinator from Delaware County PIN. She reviewed the information that was collected with the interviewed families. They concurred that the information gathered was completely accurate and represented their views. Although the outcomes presented in this paper are only a small sampling of the families involved with grant services, it was discovered when the data was analyzed, each family expressed a clear and consistent message.

All of the families interviewed were asked identical questions. The families were involved with grant services for a minimum of six months when the information was gathered. Their children are represented collectively in all of the child serving systems: mental health, mental retardation, education, child welfare, juvenile justice, and drug and alcohol. They also represent a cultural and economic diversity as well as diversity in the family's home structure. The families were selected on the basis of their availability and willingness to be interviewed.

Four questions were posed to each family during the interview:

1. What services have helped?
2. What services were somewhat helpful?
3. What additional services would still be helpful?
4. What services did not work?

Although the families interviewed were diverse, the information gathered wove a common thread. Upon reviewing the information, it became strikingly clear that families, given adequate service information, not only knew what they needed but were quick to offer suggestions on what did or did not work for their family, in addition to what they believed would help.

1. ***What services have helped?*** All respondents reported that parent advocacy and peer support were crucial services. Parents expected to continue some level of involvement with PIN once grant services were no longer desired or necessary. Overall, families had very positive comments regarding the Family First Program. This service consisted of in-home clinical interventions, with on-call crisis availability. Flexibility in scheduling and case management services were also positive features of the program. Parents noted the importance of the summer programming that their children received. Additionally, parents whose children returned from a residential facility to participate in PACC commended the child welfare case worker's continued involvement.

The smallest number of responses were listed under question #2.

2. ***What services were somewhat helpful?*** Intensive case management and multi-agency meetings were examples given.

Question #3 received the largest number of responses.

3. ***What additional services would still be helpful?*** All parents interviewed stressed and underscored the need for non-clinical community supports via social and recreational activities for their children. Of equal importance to families was the need for creative respite care. Parents were also specific about how these supports could be delivered: week-end wilderness programs, a job coach, a mentor program, or a big brother were some of their suggestions.

4. ***What services did not work?*** Parents again lamented the difficulties of securing flexible services as opposed to restrictive punitive measures in the educational system. They recounted their dismay at not receiving non-traditional supports or insufficient wraparound services.

The message that families proclaimed is clear. Although clinical interventions are a critical component, non-medical/non-traditional supports are of equal value in the compliment of children's mental health services. This message on the surface may seem simplistic and yet it's visionary. Parents themselves, being removed from the terrors of territorialism, are basically unaware of bureaucratic and fiscal restrictions. Parents need accessibility into a seamless system. They have one primary concern - that supports and services fit and meet the needs of their own child and family. It has become increasingly clear through this initiative that services and supports must be flexible, developed aside from regulatory restrictions, duplications and fiscal guidelines if children and their families are to be effectively served. Program planners, government policymakers and health insurance organizations must begin to design and budget around family-driven individual needs in regards to services if mental health benefits are to be achieved for children and families.

In spite of these enormous challenges, Pennsylvania, in collaboration with Delaware County, has been a forerunner in program development and remains committed to serving the needs of their mental health population. A willingness to share strengths as well as limitations speaks to security within their leadership. Together they deserve acknowledgement for designing and implementing a program with enormous fiscal and regulatory barriers. The families, as well, are to be commended for their patience and willingness to become demonstration instruments in grant services implementation.

Although many problem areas are identified here, parents were quick to commend the overall success of the PACC program and the services received. All but one family reported being pleased to have been given PACC priority status and acceptance into the program.

At the conclusion of each interview, families were asked to relate some quotable impressions. They include the following:

1. PACC has made me more assertive about my child's rights.
2. My child has improved because of PACC and has remained out of placement.
3. I am now viewed as part of the solution and not the problem.
4. The Parent advocate was my lifeline, without any exaggeration.
5. I am much more capable and have developed the needed expertise to function as my child's advocate and case manager.
6. The Parent advocacy program is excellent, its concept is great and also its implementation.
7. I have learned how to get things done.
8. I have learned how to be my son's advocate, case manager and social worker.
9. PACC has helped me a lot, they have been there for me.
10. My adolescent has not responded well to all the therapeutic efforts that have been given. He would probably be more responsive to recreational wraparound services given his age.

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Children and Mental Disorder in California: Preliminary Results of the Statewide Mental Health Needs Assessment

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Introduction and Background

Over the past decade there have been several reviews of epidemiologic studies of mental disorders among children and adolescents. Estimates of diagnosable disorder among these individuals have ranged from 12% in the late 1970s (Gould, Wunsch-Hitzig, and Dohrenwend, 1980) to 20% (Brandenburg, Friedman, and Silver, 1990) or 22% (Costello, 1989). Not only does the need for mental health services seem to be increasing, but the array of services available is very limited and the funding for these services is increasingly restricted due to fiscal cutbacks. These are only some of the critical challenges facing mental health services managers and researchers (Friedman and Kutash, 1992).

The dilemma faced by public mental health agencies currently experiencing these fiscal cutbacks at state and local levels is to define the number and types of children and adolescents who are most in need of public mental health services and then to identify and implement the most cost-effective service strategies available. Since there is virtually no way to serve all the children and adolescents who need some type of service, government-funded agencies must establish qualifying criteria for most in need of public services and separate out those potential clients who can access services in the private sector or who are adequately being served by other health or human service agencies, e.g., schools, health clinics, social services, or juvenile justice authorities. While we anticipate based on previous studies that about 5% to 7% of children or adolescents in the general population will be in need of specialty mental health services, some of these families have access to privately funded services and do not use public sector services.

The California Department of Mental Health was interested in undertaking a needs assessment study of households statewide to determine the prevalence of serious mental disorders within these households, for both adults and youths. The major questions regarded the numbers of seriously mentally ill persons in these households, where they received treatment services, barriers to services that they encountered, and obtaining a slightly more detailed profile of the types of disorders prevalent in the households without conducting a diagnostic interview. The study to be described represents the third stage of this investigation of serious mental disorders and their treatment in California. The first two stages entailed an extensive examination on a county-by-county basis of the treated prevalence of these disorders, and, at least for adults, the use of ECA data from Los Angeles and St. Louis to estimate the number of seriously disordered persons in each county who might seek treatment for these problems. The emphasis in this third stage of the study has been on sorting through information in a field survey not only on the prevalence of these disorders but on the number of individuals needing treatment who could be expected to seek help from local public mental health agencies.

Study Methods

The primary purpose of the Statewide Mental Health Needs Assessment is to estimate the prevalence of severe and persistent mental illness among non-institutionalized Californians living in households and to examine factors related to the use of public mental health services. To accomplish these objectives, a telephone survey was conducted with 9,143 Californian households. The primary objectives of the telephone survey were to identify and collect in-depth information about (1) adults with functional psychosis and related debilitating conditions and (2) children or adolescents with severe disabling disorders.

Working with a panel of mental health epidemiologists and other research social scientists, the Santa Clara County Mental Health Bureau's project directors developed the preliminary draft of the questionnaire for the statewide telephone survey. Then, Field Research's survey design experts worked closely with the Mental Health Bureau's project staff to refine the questionnaire in order to facilitate administration of the survey by telephone, enhance respondent cooperation, and ensure the meaningfulness of survey responses.

The final questionnaire included two parts: a screener (Part I) and an extended questionnaire (Part II). The screener was designed to collect information about up to 10 persons in a household and to identify whether any of these individuals had experienced severe emotional or mental health problems during the past year. The second part of the questionnaire was used to collect more in-depth interview, a child between the ages of 5 and 17 years of age in the household had to have satisfied at least one of the following criteria during the previous 12 months:

1. had been severely depressed, attempted suicide or had nervous or emotional problems along with severe learning problems at school, failing a grade, running away from home, or badly misbehaving for long periods of time;
2. spent time in a children's shelter, a foster home, or a residential treatment program; or
3. was determined to be "seriously emotionally disturbed" by the school system's special education program.

After the English-language version of the questionnaire was finalized, the Mental Health Bureau translated the instrument into three other languages: Spanish, Tagalog, and Vietnamese.

After the Spanish, Tagalog, and Vietnamese translations were complete, the Mental Health Bureau had them translated back into English to verify the accuracy of the translations.

Survey Sampling, Inc. generated a random sample of telephone numbers for all California households that was stratified by county. The sample of telephone numbers was designed (1) to ensure that each telephone household in California would have the same probability of selection (including households without listed telephone numbers) and (2) to represent telephone households in each of California's 58 counties in proportion to their frequency, relative to the statewide population of telephone households. The method Survey Sampling used to develop the sampling frame and select the sample of telephone numbers is commonly referred to as random-digit-dialing.

For each household included in the sample, interviews were completed with one knowledgeable adult. When a household was first contacted, the interviewer asked to speak with an adult who could discuss the health of all persons living in the household. This respondent was then asked to provide information for up to 10 persons, depending on the number of individuals living in the household.

Before beginning the interview, recruited respondents who appeared to have difficulty speaking English were offered the opportunity to be interviewed in one of the following three other languages, as appropriate: Spanish, Tagalog, or Vietnamese.

Only experienced interviewers were assigned to the project, and before conducting any interviews, they attended a training session conducted by one of field Research's project leaders, with the assistance of the Mental Health Bureau. The training sessions for the pilot tests and the full study included an overview of the project, question-by-question review of the telephone instrument, and interviewing practice. During the first few days of interviewing, interviewers were debriefed in order to compare experiences, resolve problems, and ensure that appropriate and uniform interviewing procedures were used. In addition, throughout the data collection period, Field Research and Mental Health Bureau project staff monitored interviewer performance.

Interviewing for the full study was conducted from October 1, 1992 through December 15, 1992. Initial contact attempts were made during the late afternoon and early evenings on weekdays and throughout the day on weekends, to maximize the likelihood of reaching a cross-section of households statewide. Once an eligible household was reached, appointments were scheduled, as needed, for respondents who preferred to be interviewed at another time.

Of the 9,143 screening interviews, 8,417 were completed in English, 670 in Spanish, 23 in tagalog, and 33 in Vietnamese. Approximately 23% (2,077) of the households screened included at least one person who qualified for the main questionnaire. Ninety percent (1,875) of the households that qualified for the main questionnaire, completed it.

After the data were cleaned, weights were developed to adjust for differential response rates by geographic region within California. The state was divided into 11 regions, and then weights were assigned so that the proportion of household screening interviews in each region would be the same in the sample as in the actual statewide population of telephone households.

As part of the telephone survey conducted for the Statewide Mental Health Needs Assessment, Field Research mailed a standardized questionnaire to parents of children between the ages of 5 and 17. The standardized questionnaire was developed by Dr. Achenbach at the University of Vermont and is known as the Child Behavior Check List (CBCL). The Child Behavior Check List (CBCL) has been used in other psychiatric epidemiological studies (Boyle, Offord, Hofmann, et. al., 1987; Achenbach, 1983). Although this study is a needs assessment rather than an epidemiological study, the CBCL serves as a means of verifying that the telephone interview is an accurate means of gathering this type of information.

In all households with children between the ages of 5 and 17 who had a serious emotional or mental illness, interviewers asked the adult respondent to complete the CBCL for up to two children in their household. If there was more than one child in the household with a serious mental illness, adult respondents were asked to complete a questionnaire for up to two randomly selected children who had an illness. If the household included only one child with a serious mental illness, parents were asked to complete a questionnaire for one of the other children in the household if there were any.

Adults who agreed to complete the CBCL were mailed a copy of the questionnaire with a cover letter from the California Department of Mental Health, a $5 cash incentive, and a business reply envelope addressed to Field Research. Approximately one week after the initial mailing, Field Research sent a thank-you/reminder postcard to all sample members. Approximately one week later, Field Research telephoned nonrespondents to encourage them to complete and return the CBCL. A second copy of the questionnaire was mailed to those who requested one during the reminder telephone call.

Results

A total sample of 5,194 individuals between the ages of 5 and 17 were covered in the household interview or 19% of the total sample of individuals. First we present an overview of the demographics of this group, the barriers encountered by their households in obtaining mental health services, the results from the brief screener and the extended interview, and then we describe the results for the group which qualified on the screening instrument and the scores on the Child Behavior Checklist.

Table 1

Comparison of Sex Distribution California, Full Sample and 5 to 17 Year Olds

Sex	California %	Full Sample %	5 to 17 %
Male	50.01	49.3	52.0
Female	49.99	50.7	48.0

Comparison of Racial Distribution by Household California, Full Sample and 5 to 17 Year Olds

Racial Category	California %	Full Sample %	5 to 17 %
White, not Hispanic	57.4	52.3	61.5
African American, not Hispanic	7.1	6.5	6.9
Asian/Pacific Islander, not Hispanic	9.2	3.1	3.1
Other, not Hispanic	.9	4.0	5.4
Hispanic	25.4	34.1	23.1

Comparison of Household Income California, Full Sample, and 5 to 17 Year Olds

	California	Full Sample (*N* = 9,143)	5 to 17 (*N* = 2,947)
$14,999 & under	18.9	18.0	17.6
$15,000 - $24,999	15.6	12.5	12.0
$25,000 - $34,999	14.7	13.7	12.4
$35,000 - $49,999	18.2	16.1	16.6
$50,000 - $74,999	7.6	16.4	18.2
$75,000 - $99,999	7.1	6.4	6.5
Over $100,000	7.0	5.3	5.6
Don't know	0	6.4	6.8
Refused	0	5.4	4.3

Comparison of Household Size California, Full Sample and 5 to 17 Year Olds

	California	Full Sample (*N* = 9,143)	5 to 17 (*N* = 2,947)
1 Person	23.2	18.2	0.0
2 Persons	31	31.5	5.2
3 Persons	16.6	17.5	18.5
4 Persons	14.7	17.4	35.8
5 Persons	7.6	9	23.0
6 Persons	3.5	3.4	9.1
7 Persons & up	3.5	3.1	8.3
Total	100	100	100.0

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Demographics

Fifty-two percent of these children and adolescents were males. Thirty-two percent were adolescents aged 13 to 17 years. In terms of racial categories, 52.3% were non-Hispanic white; non-white individuals were primarily Hispanic (34.1%) and African American (6.5%), Asian (3.1%). Asians were underrepresented in the sample although we attempted to include them in the sample by incorporating Asian languages. Languages represented included Spanish, Chinese, Tagalog, Vietnamese, Laotian, Cambodian, French, Portuguese and Japanese. 17.6% of the households with children in the sample reported incomes of less than $15,000; another 25% reported incomes between $15,000 and $35,000. Table 1 arrays these distributions. Comparing these demographic characteristics with statewide demographics, it appears that the unweighted sample is representative of youths 5 to 17 statewide.

Table 1 (continued)

Languages Spoken in Households
Full Sample vs. 5 to 17 Year Olds

	Full Sample (*N* = 9,143)			5 to 17 Year Olds (*N* = 2,947)		
	Count	Pct of Responses	Pct of Cases	Count	Pct of Responses	Pct of Cases
English	8,596	80.1	94.3	2,708	74.3	92.1
Spanish	1,427	13.3	15.7	731	20.0	24.9
Other	305	2.8	3.3	77	2.1	2.6
Philippino	118	1.1	1.3	44	1.2	1.5
Vietnamese	53	.5	.6	30	.8	1.0
French	85	.8	.9	20	.5	.7
Chinese	71	.7	.8	20	.5	.7
Japanese	42	.4	.5	8	.2	.3
Portuguese	26	.2	.3	7	.2	.2
Laotian	3	.0	.0	1	.0	.0
Cambodian	1	.0	.0	0	.0	.0
Total responses	10,727	100.0	117.7	3,646	100.0	124.0
	27 missing cases; 9,116 valid cases			6 missing cases; 2,941 valid cases		

Of the 5,194 youths in the household sample, 5.9% were reported to have ever had mental health treatment but only 3.3% had treatment within the past year. Household respondents also reported that they received mental health treatment from private sources primarily or mostly (2.1%). Only 0.9% of those interviewed reported receiving mostly or exclusively public mental health services. 2.3% of the sample had private insurance and .5% had Medicaid as their only third-party coverage. Table 2 portrays these distributions.

Barriers

Included in the screener was a series of questions used by Stefl and Prosperi (1985) to assess perceived barriers to mental health service utilization. Eight questions assessed availability, accessibility, acceptability and affordability. Among the households with 5 to 17 year olds, as seen in Table 3 cost was the most frequently endorsed barrier and accounted for 26.7% of the sample. The next most frequently identified barrier was accessibility or not knowing where services are located (15.4%). Finally, 17.3% of the households felt that there were no barriers in accessing services and had responded in a negative direction to all barrier questions.

Screener and Extended Interviews

Of this total sample of individuals 5 to 17 years old, 8% screened positive on any one of the questions designed to identify youths as seriously mentally ill. Specifically, youths were

Table 2
Positive Responses to Mental Health Needs Assessment, 5- to 17-Year Olds
(*N* = 5,194)

Utilization

	N	%
Ever had Mental Health Tx	304	5.9
Mental Health Tx within last yr.	169	3.3
MH 24Hr Placement	13	0.3
MH Emergency		
Once	6	0.1
Twice	7	0.1
3 or more times	5	0.1
MH visit > 12 within last yr.	52	1.0

Services Type

	N	%
All Public Sources	39	0.8
Mostly Public Sources	6	0.1
Half Public & Half Private	7	0.1
Mostly Private Sources	26	0.5
All Private Sources	84	1.6
Don't Know	6	0.1
Refused	1	0.0

Types of Insurance

	N	%
Medi-Cal	28	0.5
MediCare	2	0.0
Private	119	2.3
No Insurance	15	0.3
Don't Know	7	0.1

Table 3
Perceived Barriers to Services Response by Household

	Count	Pct of Responses	Pct of Cases
Too costly?	1,342	26.7	47.1
Don't know where	776	15.4	27.2
Miss work	760	15.1	26.6
No one to go with	448	8.9	15.7
Social Stigma	337	6.7	11.8
Other Reason	295	5.9	10.3
No transportation	202	4.0	7.1
No perceived barriers	872	17.3	30.6
Total responses	5,032	100.0	176

95 missing cases 2,852 valid cases

identified as severely mentally ill if they had persistent psychosocial problems for one year or more (3.7% were positive), were designated as seriously emotionally disturbed in the school system and required mental health services to progress in their educational setting (0.9% were positive), or had been placed out-of-home in facility (inpatient, residential care, ward of the court, foster care, or children's shelter (0.8% were positive). In addition youths were screened into the positive group if they had been placed in 24-hour care as adults (.03%), had been taken to an emergency room for evaluation (0.3%), or had received more than 12 visits of outpatient care during the previous year (1.0%). These questions qualified the largest group of respondents for the extended interview (see Table 4).

Another group of screening questions for psychiatric symptoms, those regarding depression symptoms, qualified the next largest portion of the sample for the extended interview. In Table 4, the screening questions are presented first, followed by the extended questions. Each of the main groups of screening items is presented: general child disorder screeners, depression, PTSD, bipolar, and schizophrenia and include the extended questions in each of these disorders as well.

Child Behavior Check List

The results presented here are of those individuals who scored positive on at least one screening question and on at least one symptom question. From the 130 individuals who returned the CBCL from those who qualified for an extended interview, 61 met the above mentioned criteria. Mean T scores were

Table 4

Positive Responses to Mental Health Needs Assessment 5- to 17-Year Olds (*N* = 5,194)

Child & Adolescent Screen

	N	%
5-17 Screen 1 (MH Problem)	192	3.7
5-17 Screen 2 (24hr placement)	44	0.8
5-17 Screen 3 (ID by School)	48	0.9
Hurt self or others	69	1.3
Fail grade	77	1.5
Juvenile Hall	25	0.5
Sexual Behavior Problem	18	0.3
Children's Shelter	23	0.4
Foster home	32	0.6
Residential Tx	26	0.5

Depression Screen

	N	%
Depress	126	2.4
Depress/2 wks or more	39	0.8
Anhedonia 2 wks or more	32	0.6
Depress/2 yrs or more	23	0.4
Anhedonia 2 yrs or more	11	0.2

PTSD Screen

	N	%
PTSD Screen	55	1.1
Painful Memories	23	0.4
Avoidance	17	0.3
Deterioration	10	0.2

Bipolar Screen

	N	%
Bipolar Screen	51	1.0
Highly Excitable/Sleepless	11	0.2
Abnormally Irritable	14	0.3

Schizophrenia Screen

	N	%
Schizophrenia Screen	13	0.3
Hallucinations/Delusions	3	0.1
Paranoid	12	0.2
Symptoms more than 6 months	1	0.0

calculated for this group and are compared to the scores for the normative sample. This comparison is presented in Table 5. As expected, the scores for the positive screening sample are higher than the normative scores. The T scores for Sex Problem and Somatic Complaint scales were the only T scores within the normative range (50 to 59). The remaining scores on the Withdrawn, Anxious/Depressed, Social Problems, Thought Problems, Aggressive Behavior, Internalizing and Externalizing scales range from a T score of 61.56 to 65.2 or one standard deviation above the mean. The Attention Problem and the Delinquent Behavior scales with T scores of 66.13 and 65.97 were the only two that approached the borderline clinical range.

Discussion

Overall, our results from the full sample resemble data from the more sophisticated epidemiological studies on mental illness. For example, 23% of the full sample qualified on one or more of the screening questions. For children and adolescents, 8% qualified on screening questions which is consistent with the currently identified rate of 11%. The clinical scales of the CBCL appear to be in the appropriate clinical direction for this type of screening. The children identified as needing services demonstrated elevated scores on the attention problem and delinquent scales but we are still examining the data regarding depressive disorders. Thus, the data appear reasonable and within the general range of a more extensive epidemiological study. Of these children and adolescents, 0.9% show up utilizing predominantly public services while the remaining children who were receiving services, or 2.3%, access them in the private sector. This provides public services planners with a more realistic target for resource allocation. Given the current budget crisis in California and in other public mental health systems, this information is precisely the type of information which will enable planners and clinical program managers to adjust their emphasis in service delivery toward finding and implementing the most cost-effective treatments and service strategies for those clients using public mental health services.

Table 5
Mean T Scores on Child Behavior Checklist Clinical and Symptom Scales: 5 - 17 Year Olds Who Scored Positive on 1 Screener & 1 Extended Question Compared to CBCL Normative Scores

	Mean	Std Dev	Minimum	Maximum	*N*
Withdrawn	62.61	11.14	50	94	61
	(54.0)	(5.8)			(2368)
Somatic Complaints	57.38	8.11	50	85	61
	(53.9)	(5.8)			(2368)
Anxious/Depressed	63.51	10.35	50	87	61
	(54.1)	(3.4)			(2368)
Social Problems	63.30	9.80	50	85	61
	(53.9)	(5.8)			(2368)
Thought Problems	61.56	9.46	50	82	61
	(53.3)	(5.7)			(2368)
Attention Problems	66.13	9.64	50	89	61
	(54.0)	(5.9)			(2368)
Delinquent Behavior	65.97	10.57	50	93	61
	(53.9)	(5.8)			(2368)
Aggressive Behavior	64.69	11.13	50	96	61
	(54.1)	(5.5)			(2368)
Sex Problems	50.71	3.27	50	65	21
(age 4-11 only)	(51.8)	(5.2)			(2368)
Internalizing Scale	62.46	10.55	43	82	61
	(50.1)	(9.8)			(2368)
Externalizing Scale	65.20	10.50	44	89	61
	(50.1)	(9.8)			(2368)
Total Problems	65.98	9.22	46	85	61
	(50.1)	(10.0)			(2368)

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Colorado's Parents' Satisfaction Survey: Findings and Policy Implications for Local Systems of Care

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Increasing interest in consumer satisfaction measures of mental health systems and services signals a recognition that these mental health systems must be aware of and responsive to their clients. Toward this end, a survey of 96 Colorado parents of children and adolescents with severe mental disturbance was completed. The major findings from the survey are: (1) a majority of parents reported noticing problems with their children at a very early age; (2) parents reported extensive involvement with other child-serving agencies prior to receiving mental health services for their children; (3) many of the children have had extensive contact with the juvenile justice system, especially the police; (4) parents reported needing encouragement and knowledge of specific treatments for their children from mental health professionals, (5) parent support groups can be beneficial for many; and (6) use, need, and satisfaction with mental health services patterns varied from one community mental health center to another.

Introduction

Increasing interest in consumer satisfaction measures of mental health systems and services signals a recognition that these mental health systems must be aware of and responsive to their clients. Borrowing heavily from market research, initial consumer satisfaction measures focused on adult mental health systems and on the growing awareness that appropriate mental health treatment must be client-centered (Berger, 1983; Essex, Fox, & Groom, 1981; Fawcett, Seekins, Whang, Muiu, & Suarez de Balcazar, 1982). Moreover, in the early 1980s Knitzer's research showed that among children and adolescents with severe emotional disturbance, 2 out of 3 were not receiving adequate services (Knitzer, 1982). In response, the Child and Adolescent Service System Program (CASSP) was created in 1984 by the National Institute of Mental Health "to improve the way in which children and adolescents with severe emotional disturbances and their families were offered multiagency services" (Lourie & Katz-Leavy, 1991).

Central to the CASSP initiative, Stroul and Friedman (1986) articulated two core values which emphasized the need for the system of care to be child-centered and community-based. While these two core values are recognized as the ideal, the fact remains that children and their families often are excluded from planning and implementing appropriate treatment strategies (Friesen & Koroloff, 1990). However, as families come to play a

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more important role in developing a system of care for their children, child-serving agencies will need to understand and evaluate their consumer's needs and satisfaction. Although consumer satisfaction surveys are not designed to be measures of client outcomes and are not standardized to national norms, they do provide, within the community, some baseline measures from which to evaluate parents' concerns and needs for their children and themselves.

Method

Design

The Colorado Parent's Satisfaction Survey was designed to assess how satisfied parents of children with severe emotional disturbance (SED) are with the mental health professionals who work with their children, and what the parents perceive the mental health service needs for their children are. The survey covered five areas of concern:

(1) Brief history of the child's disability

(2) Parent's relationships with professionals

(3) Parent support groups

(4) Children's mental health services

(5) Family demographics

Our purposes for the survey focused on the need: (a) to establish some baseline data for parents' perceptions of the mental health system; (b) to provide the Child and Adolescent Specialists at the various community mental health centers with a comparative analysis of the parent's perspectives in their catchment areas; and, (c) to provide the survey results to parents and representatives from child-serving agencies so that they could focus their discussions on developing an appropriate system of care in their community. Thus, our focus has been to consider the policy implications of the survey.

Initial drafts of the survey were pretested at various community forums throughout the state during the beginning stages (fall of 1990) of the CASSP grant. In addition to survey design assistance from the state's Division of Mental Health and other child-serving agency personnel, parents with children with SED were asked to read and comment on drafts of the questionnaire. Several questions, especially in the needs assessment section, were taken from Friesen's national survey of parents with children with SED (Friesen, 1989). Two survey formats, by telephone and in person, were designed to accommodate parents and to increase the ease with which the surveys could be completed. Prior to completing the survey, all respondents read and signed an informed consent form requesting their participation in the survey. All telephone interviews were conducted by trained graduate students from the Department of Psychology at the University of Colorado-Boulder. Additionally, Spanish-speaking parents could elect to be interviewed in Spanish, or they could complete a Spanish translation of the survey.

Sample

A total of 96 parents or guardians of children with SED completed the survey (21% by telephone and 79% in person). Between June 1991 and June 1992, respondents were selected by five of the six Child and Adolescent Specialists, representing Pikes Peak, Spanish Peaks, West Central, Southwest and Midwest Community Mental Health Centers; the Family Advocacy Coordinator for the Mental Health Association of Colorado; project directors from two special mental health initiatives (Colorado West and Jefferson Center); and the authors at various child/parent mental health conferences in Colorado. Project directors for the state's urban and rural demonstration projects were asked to select parents for the survey, but no questionnaires were returned. Thus, the sample is selected and nonrandom.

Ideally, we would have preferred to generate a list of all parents with children with SED, randomly select a group to interview, calculate a completion/response rate, and have our sample reflect the attitudes and opinions of all parents in Colorado with children with SED. However, access to this data base was restricted. In all, parents from seven of Colorado's twenty community mental health centers are included in the survey, giving us a relatively representative cross section of parents with children with SED who used community mental health centers in the state (88% of the parents reported using the services of one of the community mental health centers). Moreover, our sample of children and parents was comparable to other studies and data on children with SED both in Colorado and nation-wide (see Tables 1 and 2).

Table 1 shows that male children were more frequent recipients of community mental health services than female children. A sizable majority of the children with SED were white, with a representative sample of children from other races. The current age of most of the children with SED was over 12 years ($\overline{X} = 11.2$). On these basic measures, the present sample was compatible with other studies.

Consistent with the National Adolescent and Child Treatment Study [NACTS (National Adolescent and Child Treatment Study, 1988)], this study found that parents first noticed problems with their children at an early age. In fact, 57% of the parents surveyed had first noticed a problem with their child by the time the child was six (29% between 0 and 3 years old and an additional 28% between 4

Table 1
Selected Comparative Demographics of Children with SED in Colorado

Child's Gender	Colorado CASSP (*N* = 96)[1] (%)	Colorado DMH (*N* = 2126)[2] (%)	Colorado FPS (*N* = 172)[3] (%)	Colorado NACTS (*N* = 180)[4] (%)	National FAP (*N* = 965)[5] (%)
Male	65	54	58	68	73
Female	35	46	42	32	27
Child's Race					
White	77	82	(Only parents' race reported)	74	86
Black	5	3		8	7
Hispanic	13	13			2
Native Am.	4	1.5			1
Other	1	0.5		18	4
Child's Age (current)					
0-5	7				4
6-11	39				37
12+	54				58
Mean Age	11.2 years				
Child's Age (lst noticed)					
0-3	29			22	
4-6	28			37	
7-9	15			18	
10-12	11			12	
13+	17			11	
Mean	6.53 years			6.90 years	

[1] Moynihan, Forward, & Stolbach (1993).

[2] Colorado Division of Mental Health (1992). The *N* = 2126 represents the total number of open cases of children 0-17 in the seven CMHCs included in this study. In all twenty CMHCs there were 5687 open cases of children 0-17.

[3] Colorado Division of Mental Health (1991). The *N* =172 represents the number of children at risk of out of home placement from a survey of 113 families served from January through September of 1991 by five existing Family Preservation Services (FPS) programs.

[4] National Adolescent and Child Treatment Study, (1988).

[5] Friesen, B.J. (1989). The *N* = 965 represents 8 percent of the total number of written, mailed questionnaires distributed through various Families as Allies conferences, parent organizations, and state mental health programs from May 1987 through August 1988.

and 6 years old), with a mean age of 6.53 years Moreover, of the 57% of the children with SED reported to have first exhibited problems between 0 and 6 years, 42% were male (a finding also consistent with the national NACTS study (Silver, et al. ,1992)).

Table 2 indicates that the majority of survey respondents were the child's mother, with about half (51%) not married. Similar to Colorado's Family Preservation Services study, many of our respondents had incomes below or near poverty level. Our respondents' education levels were comparable to both the Family Preservation Services and the NACTS studies' samples, but somewhat lower than the Families as Allies Project sample. The Families as Allies Project survey used a national sample of parents with children with SED not limited to a community mental health center population, and the study showed a marriage rate as well as education and income levels higher among their respondents than the respondents in this study.

Table 2
Selected Comparative Demographics of Survey Respondents with Children with SED in Colorado

Respondent's Relationship to Child	Colorado CASSP (*N* = 96) [1] (%)	Colorado FPS (*N* = 172) [2] (%)	Colorado NACTS (*N* = 180) [3] (%)	National FAP (*N* = 965) [4] (%)
Mother	76			71
Stepmother	2			1
Foster Mother	2			4
Adoptive Mother	5			10
Father	11			9
Other	4			5
Respondent's Marital Status				
Married	49			66
Single	5			34
Divorced	34			
Separated	9			
Widowed	3			
Respondent's Education				
High School or less	19	34	20	9
High School diploma	18	27	33	24
Business/Trade	10			10
Some College	33	31	34	27
College degree	11	8	7	11
Some Graduate school	4		3	8
Graduate degree	6			12
Yearly Household Income				
<$10,000	42	(50% of	28	20
$10,000-19,999	29	households	33	22
>$20,000	30	<$9,650)	39	58

[1] Moynihan, Forward, & Stolbach (1993).

[2] Colorado Division of Mental Health (1991). (The *N* = 172 represents the number of children at risk of out of home placement from a survey of 113 families served from January through September of 1991 by five existing Family Preservation Services (FPS) programs).

[3] National Adolescent and Child Treatment Study, (1988).

[4] Friesen, B.J. (1989). The *N* = 965 represents 8 percent of the total number of written, mailed questionnaires distributed through various Families as Allies conferences, parent organizations, and state mental health programs from May 1987 through August 1988.

Results

Child's Service History

In addition to a relatively young age for the onset of a mental health problem, most parents (57%) reported that their children were given a diagnosis for their disability. While this is a somewhat low percentage of reported diagnosis, it may reflect a reluctance on the part of the parents to discuss the specific mental health disability of their child. Among those who said they were given a diagnosis for their child ($n = 55$), parents reported the following mental health disorders:

Disorder	%	Group %	Group Name
Abuse-phy/neglect	4	19	Abuse
Abuse-Sex	11		
PTSD	4		
ADD/ADHD	42	42	ADD
Conduct Disorder	6	15	Personality
Character Disorder	9		
Depression, Major	9	20	Affective
Depression, Bi-Polar	11		
Other	5	5	Other

It is difficult to compare these diagnoses with state-wide community mental health centers' diagnoses, because parents' reports do not necessarily reflect the official diagnosis. Moreover, record keeping and diagnostic categories tend to vary from one mental health center to another.

When diagnosed, males were most likely to be characterized as having Attention Deficit/Hyperactive Disorder (ADD) (55%) or Depression (26%), while females were most likely to be regarded as having been abused (41%) or having a Conduct or Character Disorder (24%). There were no major differences by race, although minorities tended to be underrepresented as having been diagnosed in the first place (82% of all reported diagnoses were for Caucasians). By income group, low income respondents (less than $10,000 per year) reported a high incidence of abuse (60% of all reported abuse diagnoses), while higher income respondents (more than $20,000 per year) mentioned ADD (35% of all reported ADD diagnoses) and Depression (45% of all reported Depression diagnoses) as common mental health disabilities for their children.

Prior to receiving some mental health service, about four out of five parents (79%) reported that their child's problem came to the attention of other child-serving agencies in the community ($\bar{X} = 2.01$). Overall, about three out of five parents (62%) mentioned schools as being involved with the child for emotional/behavioral problems (48%), academic/behavioral problems (20%), special education (10%), and other problems (testing, abuse/neglect reports, etc.). Two out of five parents (41%) mentioned involvement with departments of social services for abuse reports on the parents (42%) or to report abuse (26%), and for other issues (protective custody, parent asked for help, etc.). More than one third of the parents (37%) reported police involvement with their child prior to receiving mental health services for theft (23%), child abuse reported to the police (20%), runaway (17%), and other problems with the police (burglary, joy riding, and other felonies and misdemeanors). A quarter of the parents (25%) mentioned that courts were involved with their child for delinquency adjudication (59%), abuse/neglect hearing (18%), or for other issues (custody hearings, specific offenses, etc.). About one out of five of the parents (17%) also reported their child's involvement with the Division of Youth Services for correctional programs, and an additional one out of ten (12%) reported involvement with hospitals, mostly for physical problems associated with abuse and/or neglect.

As noted above, prior to receiving mental health services, most parents and their children had extensive involvement with other child-serving agencies. Table 3 indicates the relative degree of satisfaction parents feel toward these other child-serving agencies. On a scale of 1 to 3 (where 1 indicates very satisfied and 3 indicates *not very satisfied*), parents were not very satisfied with social services ($\bar{X}$ = 2.20), schools ($\bar{X}$ = 2.15), or the courts ($\bar{X}$ = 2.12). For each of these agencies, one third or less of the parents say they were very satisfied with how their child was handled by the specific agency. Parents were somewhat ambivalent toward youth services ($\bar{X}$ = 2.00), while the police agencies received the highest level of parent's satisfaction ($\bar{X}$ = 1.17).

Parent's higher satisfaction with the police may be partially explained by their ability to re-establish some semblance of order by reducing aggressive behavior, removing out-of-control family members from the home, or by taking an abused child from the home when other measures of social control have failed. Moreover, parents reported that in a few instances the police officer, on his or her own time, returned to the home to see how the family was doing.

Table 3
Parent's Satisfaction with Specific Agencies Prior to Receiving Mental Health Services (*N* = 76)

			Satisfaction (%)				
Agencies	*N*	Total %	Very	Somewhat	Not Very	DK/NA	Mean
Schools	59	62	29	25	44	2	2.15
Social Services	39	41	28	23	49	0	2.20
DYS	16	17	38	25	38	0	2.00
Police	35	37	44	36	17	3	1.71
Courts	24	25	32	24	44	0	2.12
Other	11	12	50	25	25	0	1.75

Scale: 1 = Very
2 = Somewhat
3 = Not Very

Parents' and Professionals' Relationships

Once their child was undergoing treatment or receiving services, things began to improve for the parents. Most parents (76%) reported that they were informed about their child's progress during treatment and, generally, two thirds (68%) say they got along very well with the professionals working with their child. Moreover, three quarters of the parents (77%) reported that the professionals working with their child suggested that they would like to include the parents and the family in deciding the best treatment plan or service for their child. When parents were asked which one of all the professionals who have worked with their child has been most involved, about two out of five (38%) mention their child's therapist/counselor, followed by the psychologist (25%), psychiatrist (2%), or M.D. (3%). Twenty seven percent of the parents also mentioned frequently direct service personnel such as school teachers/counselors, social workers/case workers, probation officers, etc. as the most involved professional working with their child. Parents also found that these professionals were helpful in a variety of ways. Table 4 reports parents' responses to an open-ended question concerning the most common ways that the most involved professionals had been the most helpful with their child. These included providing encouragment, understanding and support (26%), keeping the parent informed about the child's progress (14%), providing specific activities/therapies (14%), helping the child improve (11%), and teaching the parent how to help the child (7%).

About one parent in five (20%) felt that even the most involved professional could have done additional

Table 4
Ways the Most Involved Professional has been Most Helpful with the Child (*N* = 91)

		Most Involved Professional		
Ways Most Helpful	Total %	Psychologist (Ph.D.)	Therapist (M.A.)	Direct Service
Provided encouragement, understanding and support	26	37	22	21
Kept parent informed about child's progress	14	0	17	25
Provided specific activities (therapies, etc.)	14	17	8	21
Therapist helped child improve	12	10	11	17
Taught parent how to help child	7	7	11	0
Provided options, alternatives and plans	6	13	3	0
Invited parent input and involvement	3	0	3	8
Helped parent gain insight, understanding	3	7	3	0
Other	14	10	19	8

things to help them cope with their child. These parents felt that parents should be given additional education/skills to help the child (22%), that the professional should work with the family more closely and listen more (13%), that the family should have a specific resource, e.g., Big Brother (13%), or that there should be better information available on mental health services. Overall, when parents were asked to consider the various professionals used and services accessed in working with their child, about two parents in five (38%) reported that the professionals and services were very effective, half (51%) felt they were somewhat effective, and one parent in twenty (5%) said they were not very effective.

Parent Support Groups

To gain some understanding of the parents' interest in support/self-help groups, they were asked if they had ever participated in such a group. Slightly more than one third of the parents (36%) indicated that they had participated, and participation was more likely among parents of higher income (more than $20,000) and higher education. Participation in support groups also was more likely among parents if their child had been diagnosed, and within the diagnosis, if the child had been abused or classified ADD.

Among those who did not participate in a support group (*n* = 60), about one in five (22%) said the reason they did not participate in a support group was because there were no support groups in the area. More than two parents in five (43%) said they chose not to join a support group, and one third of these parents were not sure about joining a support group. Of those who did participate (*n* = 36), a solid majority (70%) said that the support group met their needs, one in seven (14%) said it did not, and one in six (16%) were unsure.

Among those who participated in a support group or expressed some interest in joining one (*n* = 77), very few (4%) said the group should be composed only of parents, a majority (61%) said the group should be made up of parents and professionals, and nearly one in five (17%) felt the group should be made up of parents, professionals, and children. About one parent in ten (12%) was unsure of the support group composition, and a few (7%) suggested other combinations.

When those who were in a support group or expressed some interest in joining one were asked about the types of support they would find helpful, all of the categories listed were ranked high (on a scale of 1 to 5 where 1 is least helpful and 5 is most helpful, the means ranged from 3.97 to 4.55 for the 10 types of support listed). In rank order, parents reported that help coping with raising a child with emotional problems would be most helpful, followed by emotional support, educational programs and systems, information on disorders and treatment, learning to coordinate and find services, coping with an emergency, long-range planning, sharing experiences, financial, and legal rights and issues.

Children's Mental Health Service Use, Need, and Satisfaction

Table 5 summarizes the parents' perception of the mental health service use, need, and satisfaction with those services for their children. Of the several mental health services listed, parents reported having used, on average, slightly over eight of these services ($\bar{X}$ = 8.03). Overall, parents reported that the mental health services which had the highest use, need, and level of satisfaction were counselor/therapists and psychologists. Services which had high use and need, but moderate to low satisfaction were classroom services and psychiatrists. A service which had high use, moderate need,

Table 5
Children's Mental Health Services (*N* = 96)

	Ever Used		Need (%)			Satisfaction (%)		
Service	N	%	a lot	a little	not at all	very	somewhat	not
Classroom	66	72	65	14	21	39	37	24
Special Education	40	43	43	17	40	54	23	23
Psychiatrist	52	56	46	21	33	53	36	11
Nurse	16	17	10	11	80	44	38	19
Lawyer	45	48	33	22	45	42	46	12
Therapist/Counselor	77	83	74	15	11	75	18	7
Social Worker	56	60	38	22	40	48	27	25
Psychologist	62	67	57	14	29	70	16	14
Minister	33	36	31	19	50	72	17	10
Outreach	21	23	36	15	50	44	33	22
Health	42	45	33	19	49	57	29	14
Recreation	26	28	31	23	46	56	37	7
Case Management	23	24	35	21	44	65	22	13
In-Home Service	12	13	21	11	69	70	10	20
Home-Builders	7	8	22	13	65	80	0	20
Residential	21	23	15	10	76	56	11	33
Foster Care	14	15	11	5	84	18	27	55
Day Treatment	19	20	29	3	68	50	31	19
Advocacy	23	25	44	11	45	64	27	9
Financial	43	46	60	10	30	50	33	17
Parent Support	31	33	50	24	26	73	17	10
Sibling Support	14	15	41	16	43	85	0	15
Crisis Intervention	22	24	37	11	52	39	44	17
Respite Care	6	7	37	12	51	43	43	14

and low satisfaction was social/case worker. Lawyers and health services had moderate use, need, and satisfaction. Special education and financial services had moderate use, high need, and moderate satisfaction. Parents' support groups had moderate use, high need, and high satisfaction. Four services which had low use, moderate need, and moderate to low satisfaction were outreach, respite care, recreation, and crisis intervention. Advocacy, case management, ministers, and sibling support groups had low to moderate use, moderate need, but high satisfaction. In-home, homebuilders, and day treatment services had low use and need, and moderate to high satisfaction. Finally, foster care, residential, and nurses had, from the parents' perspective, low use, need, and satisfaction.

Although Table 5 represents an overall perspective of children's mental health service use, need, and satisfaction, when these services were broken out by the seven community mental health centers included in this study, a diverse pattern of use, need and satisfaction emerged. That is, while most parents reported that their children had a high need for services such as counselor/therapists (75%), classroom (65%), and psychologists (56%), other service needs varied greatly depending on the particular community mental health center's catchment area. Space does not permit reporting the use, need, and level of satisfaction for all of the services tested in all seven community mental health centers, although this will be done in separate reports to the parent groups and the community mental health centers. However, each of the catchment areas had particular use, need, and satisfaction profiles. For example, while about two out of five parents, overall (42%), reported using special education services, the range of use went from a high of 63% at one community mental health center to a low of 18% in another. Similar wide ranging use patterns were found for most of the mental health services.

Moreover, mental health service needs varied from one community mental health center to another. Overall, almost half of the parents (46%) reported, for example, that their children needed psychiatrists a lot. However, about two thirds of the parents (67%) at one community mental health center and none at another reported needing psychiatrists a lot. Similarly, parents' satisfaction with the several mental health services varied greatly among the parents from the seven community mental health centers.

Policy Implications

The parents' views of their children's mental health service needs presented in this paper provide one a perspective on the components needed to develop a local system of care. Certainly, professional care givers may have other perspectives. For example, Turpin notes in his study of 3,398 child care givers in Washington that "Of all residential/inpatient services, foster home placement and group home placement were the most commonly reported service needs." (Turpin, Forsyth-Stephens, & Low, 1991). The parents included in this study, conversely, reported very little need for out-of-home residential services, especially foster home services. The important point is not necessarily which perspective is "right", but rather that both perspectives should be considered when communities develop appropriate systems of care for their children.

Moreover, based on our research findings, several local system of care policy issues stand out:

- The fact that nearly three out of five parents (57%) reported noticing problems with their children between 0 and 6 years of age, indicates a need to develop more extensive outreach programs and more extensive mental health testing at an earlier age.
- Given that prior to receiving mental health services, parents reported a great deal of involvement with other child serving agencies, these other agencies need to be more sensitive and involved with the

parents and the community mental health centers in developing a local system of care.

- Our research findings indicate that many of these children have extensive contact with the juvenile justice system, especially the police, yet the police are rarely included in the overall agency mix in the local system of care. The police have knowledge of the community which could be beneficial to mental health workers and, in turn, mental health personnel could develop with the police more extensive mental health recognition and coping training.
- Our research findings indicate that parents found that the most helpful mental health professionals were able to provide both support and encouragement as well as knowledge of and specific treatments for their children. Appropriate systems of care should be able to offer parents both the process (support) and the product (treatment).
- While parents' support groups are beneficial for many, they are not for everyone. Moreover, they should include both parents and professionals and, should the group decide, children.
- In terms of mental health service use and needs, parents focused most commonly on their children's needs. Additionally, use, need, and satisfaction patterns varied from one community mental health center to another. Thus, children's mental health service needs are not evenly distributed throughout the state. This means that a viable local system of care must reflect the local patterns of mental health service needs.

Essentially, those things that parents said their children need reflect a strong desire on the parents' part to keep their children at home, if they are given support and skills from the local system of care. With adequate support and help, parents would choose residential treatment for their children only as a last resort. Clearly, the need to involve parents at all levels from policy making to day-to-day implementation of the local system of care is imperative.

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Comprehensive Services to Families as a Means for Prevention

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The Community-Family Partnership (CFP) Project is one of 34 service demonstration projects funded by the Administration for Children and families. The CFP is in its fourth year of operation. The major goals of the project are to break the cycle of poverty and its impact by working in partnership with families to assist them in maximizing the development of each child under age five; to prevent abuse, neglect, school drop-out, and mental health problems; and to help the family achieve economic self-sufficiency. The project provides individualized, comprehensive, intensive, ongoing services to 60 poverty-level families. After individual and family goals are established in a family-based support plan, project staff assist families in accessing existing community services, provide direct services, create new services, and pay for services, as needed. Comprehensive services are provided in areas such as prenatal care, nutrition, health care, mental health, substance abuse treatment, housing, and child development. Preliminary data show success.

The Community-Family Partnership Project

The Community-Family Partnership Project (CFP) is one of 34 Comprehensive Child Development Programs (CCDP) funded by the Head Start Bureau of the Administration for Children, Youth and Families (1988). The CCDP's are service demonstration projects. The goals of the CCDP's are:

1. To break the cycle of poverty
    a. by maximizing the development of each child under age 6, and
    b. by helping families become economically self-sufficient.
2. To evaluate the impact of comprehensive, ongoing, individualized, long-term services on poverty level families.

Eligibility

The eligibility requirements for families at the time of enrollment include having: (a) An income less than Federal Poverty Guidelines (e.g., less than $16,810 for a family of five), and (b) a pregnant woman or child under age one in the home.

Once a family is enrolled, they remain eligible regardless of income as long as the focus child (child under age one who was used to determine eligibility) remains in the home. The intent is to provide intensive, comprehensive, ongoing services to families for five years.

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[1] The views expressed in this paper are the sole responsibility of the author and do not necessarily reflect the views of the Administration of Children, Youth and Families.

A total of 180 families who met the eligibility requirements were recruited. These families were randomly assigned so that there were 60 in a Program Group (intervention), 60 in a Comparison Group (control), and 60 in a Replacement Group in case any families dropped out of either of the other two groups. Table 1 provides a summary of the demographics of the families currently enrolled in CFP.

Table 1
Demographic Information for Families Enrolled in the Project from 1/1/93 to 1/31/93

Variable	N	%	Mean
Marital Status of Mother			
1. Married	41	69.4	
2. Single	6	10.1	
3. Widowed	0	0.0	
4. Divorced	9	15.2	
5. Separated	1	1.6	
6. Single, living with partner	2	3.3	
Total	59	100.0	
Ethnicity of Mother			
1. American Indian	5	8.4	
2. Asian or Pacific Islander	2	3.3	
3. Black, not of Hispanic Origin	0	0.0	
4. Hispanic	3	5.0	
5. White, not of Hispanic Origin	49	83.0	
Total	59	100.0	
Primary Language of Mother			
1. American Indian	3	5.0	
2. Asian	2	3.3	
3. English	52	88.1	
4. Spanish	2	3.3	
5. Other	0	0.0	
Total	59	100.0	
Years of Education			
1. Father	46		12.3
2. Mother	59		11.7
Parents Ages (in years)			
1. Father	46		31.5
2. Mother	59		28.9
Number of Adults (age 18 and over)	109		
Number of Children	205	100	
1. 0 to 1 year	15	7.3	
2. 1 to 2 years	22	10.7	
3. 2 to 3 years	34	16.5	
4. 3 to 4 years	20	9.7	
5. 4 to 5 years	16	7.8	
6. 5 to 6 years	19	9.2	
7. 6 to 18 years	78	38.0	
Average Family Size			5.23

Geographic Area

The CFP Project serves two rural counties, Cache and Box Elder counties, in northern Utah. The counties have a combined population of 106,668 people and a geographic area of 6,888 square miles. Over 13.2% of the population in the two counties have an income below the Federal poverty level (1987). Cache County is separated from Box Elder County by a chain of mountains. Housing is expensive because of a 25% increase in the number of students (3,000 more) enrolled at Utah State University in the last two years. There are a limited number of employers who provide a good wage and benefit package and wages are low because employers can hire college students at minimum wage. Box Elder County is divided up by the great Salt Lake. Morton Thiokol, a major employer, is reducing its work force because of the national shift from defense and space exploration spending causing employment problems.

Partnerships

The CFP believes in establishing both formal (having written agreements) and informal partnerships to achieve its goals. At present, there are 393 partnerships between the

Table 1 (continued)
Demographic Information for Families Enrolled in the Project from 1/1/93 to 1/31/93

Variable	N	%	Mean
Parent Employment and Projected Yearly Income			
Father	46	100.0	$13,251.66
1. Employed	39	84.7	$15,630.17
2. Unemployed	7	15.2	
Mother	59	100.0	$4,032.71
1. Employed	29	49.1	$8,204.49
2. Unemployed	30	50.8	
Family	60	100.0	$15,284.52
1. Employed	52	86.6	$17,635.98
2. Unemployed	8	13.3	
Telephone in the home			
1. Yes	53	89.8	
2. No	6	10.1	
Own Transportation			
1. Yes	56	94.9	
2. No	3	5.0	
		Subsidized?	
Housing		yes	no
1. House	38	9	29
2. Apartment	17	8	9
3. Mobile Home	3	0	3
4. Shelter	1	0	1
5. Other	0	0	0
Total	59	17	42

* Projected income is based on monies earned and time employed during the period 1/1/93 to 3/31/93

CFP Project, 60 families and community agencies. Ninety-nine of these partnerships have written interagency agreements which specify the services and costs for which each agency is responsible.

Families are involved in the project in numerous ways, including partnerships with staff and agency personnel, membership on the project's Advisory Board, membership on a Parent Council with the freedom to develop its own agenda and conduct its own activities (they have their own budget), and parent support and education groups. The intent is to have families control their own destiny.

Core Services

Figure 1 provides an overview of the core services mandated by the funding agency. The CFP Project is expected to:

1. access existing services where ever possible;
2. help create services needed to fill gaps in services provided by other agencies (e.g., Children's Mental Health), and where no services presently exist (e.g., preschools services for 3-year olds);
3. provide some direct services (e.g., parent training in child development); and
4. serve as payor of last resort.

Program Evaluation

The evaluation of the CFDP's consists of several parts:

1. An independent contractor (Abt. Associates), is hired by the government to assess both program and comparison group families. No feedback is given to project staff.
2. A Management Information System is used by a second government contractor (CRS, Inc.) as a process evaluation. The information for this system is supplied by the project to the Federal Government, is all computerized and is available to the project for use.
3. A part-time ethnographer located on the campus at Utah State University collects qualitative data. Three reports are submitted to CSR, Inc. yearly.

Ethnography reports are available to the project.

4. Individual family and family member progress data on goals set for the Family-Based Support Plan (FBSP) and for each child's Individual Child Development Plan (ICDP) is collected. This information is collected by project staff and is used for a variety of planning and intervention purposes. Some of this type of data will be presented herein.

Management Information System

Data is collected on every aspect of the project using a computer based Management Information System. The information collected includes items such as information on every agency contact, the amount of time spent on each activity during home visits, and copies and updates of the FBSP.

Service Process

After enrollment, a needs assessment is conducted on each family and each person therein. A variety of processes, including interviews and checklists are used to assess needs and strengths in each of the core service areas shown in Figure 1.

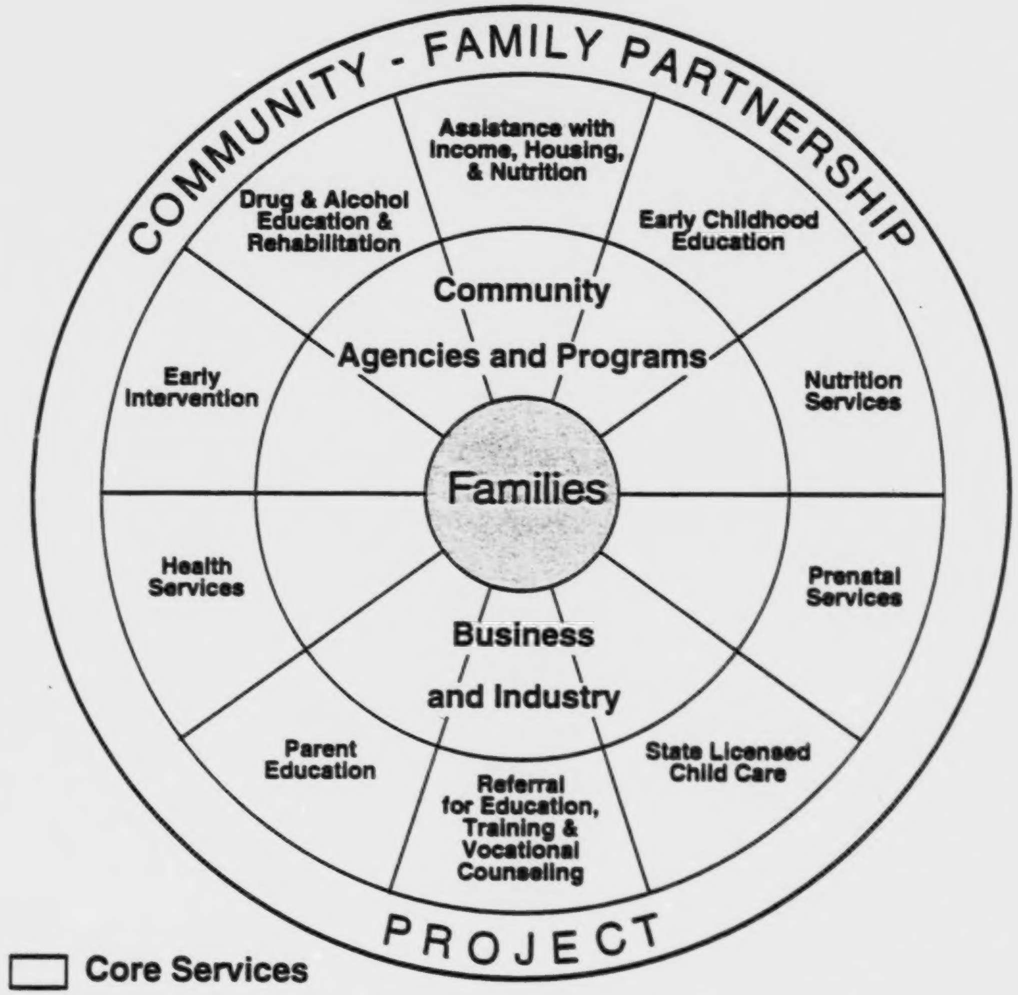
The core services are the major areas in which the project will help families access existing services, create new services, provide services directly or pay for services. All needs which a family identifies for translation into goals are addressed. The goals are used to write an individualized FBSP for the family and an ICDP for each child under age six. These plans serve to guide the activities of the family and CFP partnerships. The plans are formally evaluated, revised, and updated every four months. Goals and activities are updated as needed.

Staffing Pattern

A wide variety of positions and disciplines are included on the staff. These include:

1. A 40% Time Project Director (licensed psychologist) who oversees all aspects of the project.
2. A 40% Time Project Co-Director/ Assessment Supervisor (licensed psychologist) who oversees all assessments and who assists the Project Director in overall project management.
3. A 100% Time Program Administrator (doctoral-level psychologist) who oversees day-to-day program implementation.
4. A 100% Time Community Liaison (MA-level health educator) who helps individuals acquire needed job skills, continuing education, and who interfaces with potential employers and employment-related agencies like Vocational Rehabilitation, JOBS, etc. The Community Liaison has the assistance of several part-time assistants.
5. A 100% Time Data Coordinator (MA in child development) who manages the data for the Management Information System, project reports to the government quarterly, and reports needed by project staff.
6. Two full-time Early Childhood Teachers (certified teachers) who manage a very structured preschool classroom in each county which is available to all 3-year olds enrolled in the project.
7. The equivalent of 3 1/2 Classroom Aides to assist the early childhood teachers.
8. Three half-time Psychoeducational Staff Assistants who conduct needed assessments, write reports, gives feedback to parents, and assists staff in other activities as needed. All are doctoral psychology students. Two of them also provide limited in-home mental health services.
9. Two half-time Staff Assistants (BA in health education and BA in psychology) who assist staff in a variety of other activities.
10. A 25% Time Ethnographer (Ph.D. in instructional technology) who does qualitative assessment of all Project

Figure 1
Core Mandated Services


COMMUNITY - FAMILY PARTNERSHIP
PROJECT
Assistance with Income, Housing, & Nutrition
Early Childhood Education
Nutrition Services
Prenatal Services
State Licensed Child Care
Referral for Education, Training & Vocational Counseling
Parent Education
Health Services
Early Intervention
Drug & Alcohol Education & Rehabilitation
Community Agencies and Programs
Families
Business and Industry
☐ Core Services

activities with a different focus every four months.

11. A 100% Time Administrative Assistant who works with the Project Director to arrange meetings, filter information, supervise secretaries, arrange travel, etc.
12. Two full-time Secretaries who assist staff on a wide range of secretarial tasks.
13. A 50% Time Child Care Specialist (MA in child development) who arranges child care for families seeking employment, continuing their education, attending meetings or appointments, or needing respite care.
14. A 50% Time Parent Training Specialist (MA in child development and family life) who arranges parent support groups, group training (e.g., budgeting classes, relationship issues), and who serves as a liaison to a project parent council.
15. The equivalent of a 100% Time Men's Issues Specialist (2 people) who work with individual fathers in the project, conduct or arranges group training activities, and who are developing a fatherhood program and curriculum designed to provide more options for involvement of fathers from families served.
16. A 100% Time Family Consultant Supervisor/Mental Health/Substance Abuse Counselor (licensed psychologist) who supervises the activities of the family consultants and their training and who problem solves. This person also screens all mental health and substance abuse issues and decides which will be dealt with by project staff and which will be referred to partner agencies.
17. The equivalent of six full-time Family Consultants (degrees in social work and child development) (1 per 10 families) who make home visits, conduct at least three 30-minute child development training activities in the home per month per child under age 6, conduct case management activities, provide support and training to parents, works in partnership with families, and broker services. These are the major liaison with each project family.
18. A 50% time Health Care Specialist (nurse) who coordinates all dental and physical health care needs.

Some other staff being recruited include:

1. A Ph.D. psychologist to provide more in-home mental health services.
2. An additional family consultant to serve as a backup when staff are ill or on vacation and to reduce the number of families served by each family consultant.
3. A child development specialist to help integrate child development activities into each family's daily routine, and to provide more child development training to the family consultants.

Data

Some data on family progress to date follow in Table 2 and Figures 2-9. The data are somewhat self-explanatory; thus, for purposes of brevity only a brief statement will be made about each. The majority of families that drop out of the project do so in the first month when they learn what the project entails (e.g., weekly in-home visits). Thereafter, most drop-outs (44.7%) occur because of better job opportunities elsewhere (Figure 2). Most families are making good progress on the goals they have set (Figures 3 & 4), and the average earned income has almost doubled from about $7,300 at enrollment to $13,800 now (Figure 5). In addition, many more families are employed now (52% to 85%, Figure 6). More families are accessing mental health services (Figure 7) and getting their children immunized (Figure 8). Birth weights, gestation time and method of delivery have improved slightly (Figure 9) and more families have completed or are completing additional education (Table 2). Most of these factors, when combined with impacts in other core service areas, should result in healthier families and children both physically and mentally. Child assessment data from test to retest on the Battelle Developmental Inventory are being evaluated now to determine the level of gains.

Summary

It appears to date that providing intensive comprehensive, ongoing services in any and all areas of need identified by families served results in progress on enhancing child development and on moving toward economic self-sufficiency. The model used involves comprehensive wrap-around services provided by partnerships consisting of project staff, families and numerous community agencies. The CFP model has many implications for mental health programs, most of which are just now being explored.

Table 2
Education and Training Activities While Enrolled in CFP
(*N* = 109)

Education/Training	# Who Completed Classes	# Now Enrolled in Classes	# Who Completed Prg/Degree	# Now Enrolled in Prg/Degree
High School/GED	n/a	n/a	11	14
Vocational/Tech.	53	20	8	3
College/University	11	3	1	18

Figure 2
Number of Program FamiliesTerminated
by Months of CFP Service
(*N* = 93)

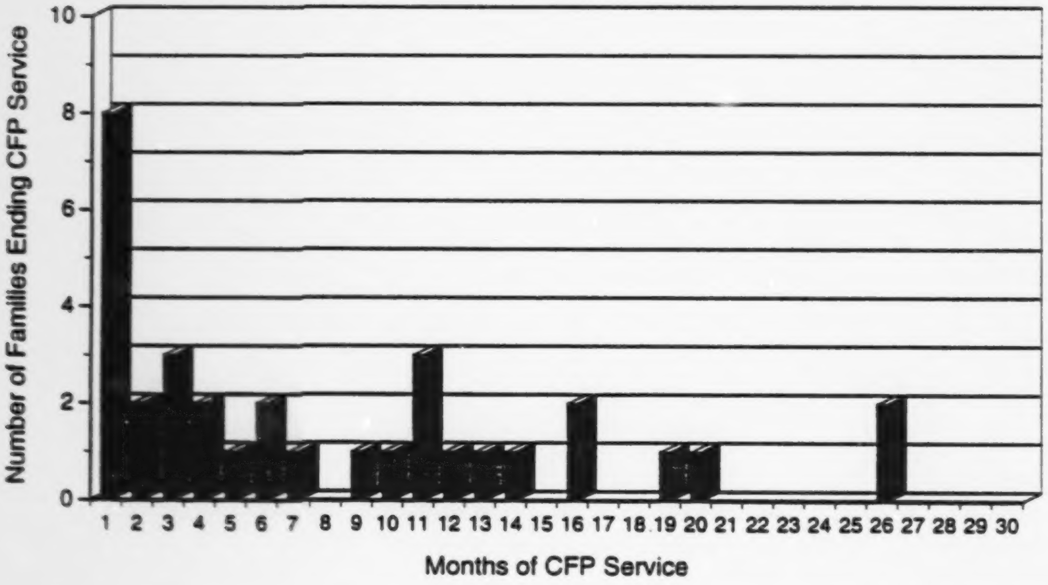


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Figure 3

Number of Needs, Goals, Completed Goals, Active Goals, and Inactive Goals for Families Enrolled During 10/1/91 to 12/31/92 for Child (1-5) and Adult (6a-99) Core Services

(child *N* = 120; adult *N* = 105)

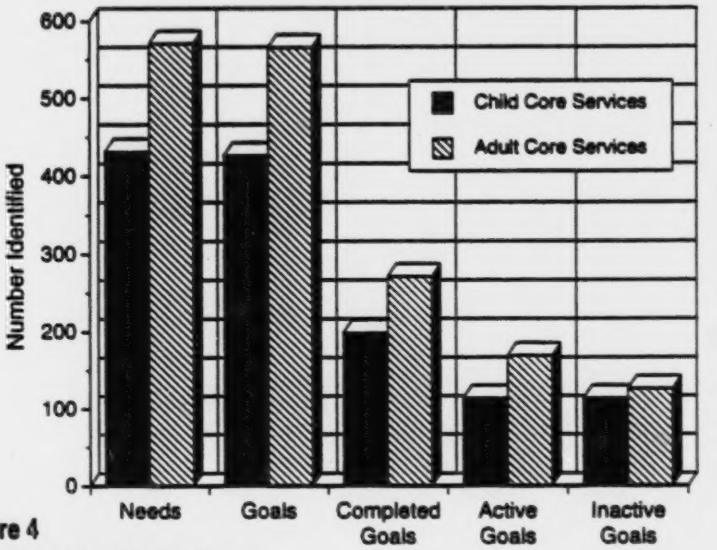


Figure 4

Total Number of Needs, Goals, Completed Goals, Active Goals, and Inactive Goals for Families Enrolled 10/1/91 to 12/31/92

(*N* = 225)

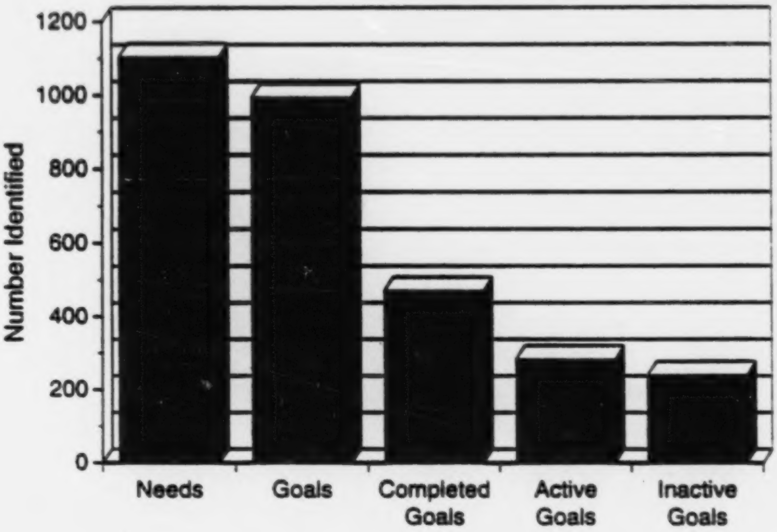


Figure 5
Average Projected Yearly Income Based on Income Earned by Fathers, Mothers During Period of CFP Service

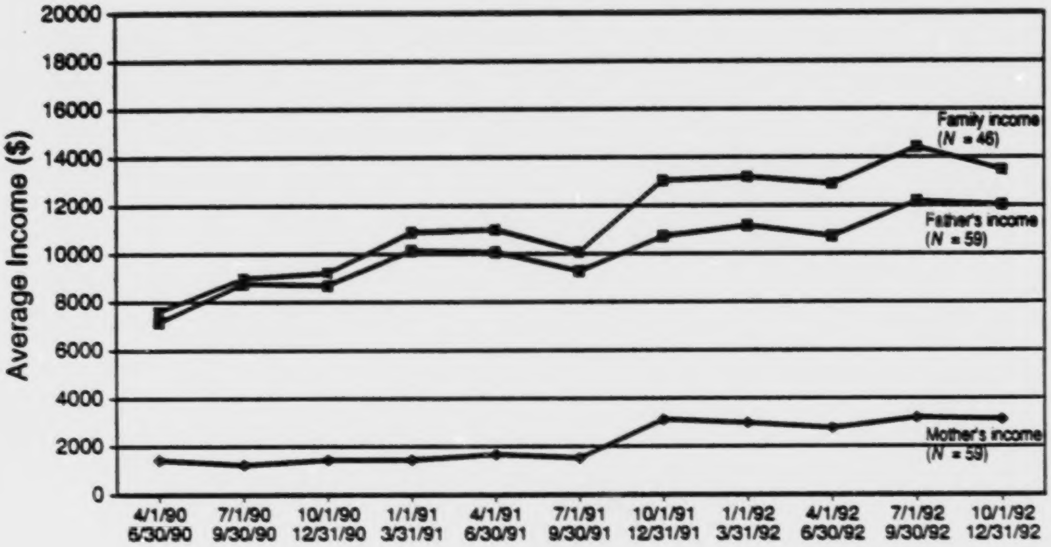


Figure 6
Percent of Fathers, Mothers, and Families Employed Each Quarter of CFP Service

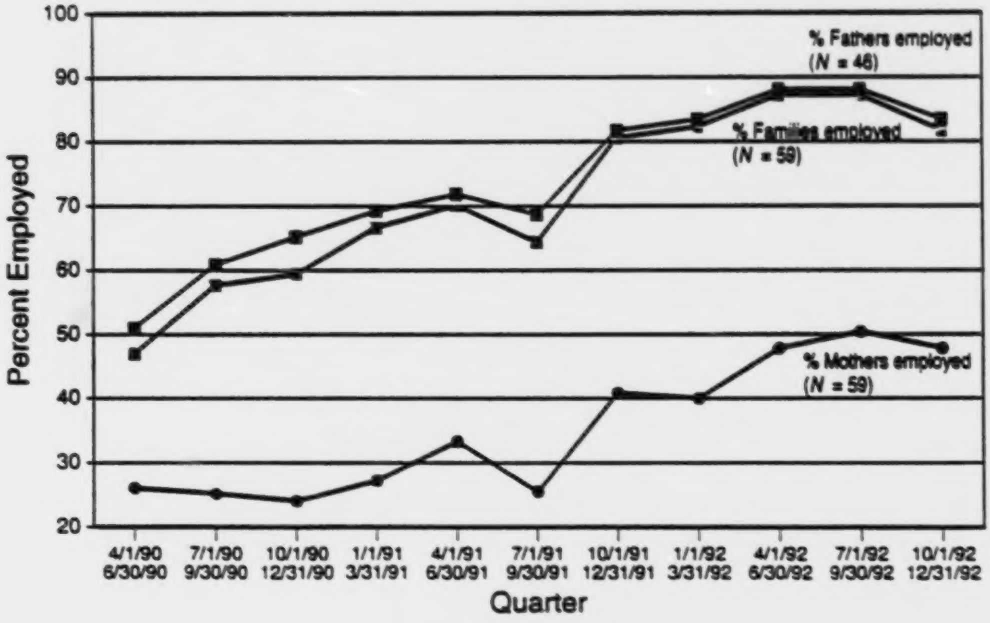


Figure 7
Number of CFP Program Family Members Receiving Mental Health Services and Substance Abuse Services Before and After CFP Enrollment
(*N* = 314)

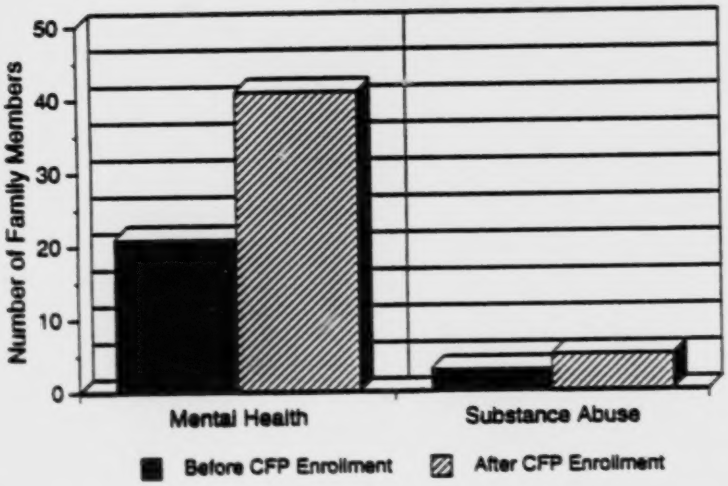


Figure 8
Percent of Children Receiving Immunizations Before and After CFP Enrollment

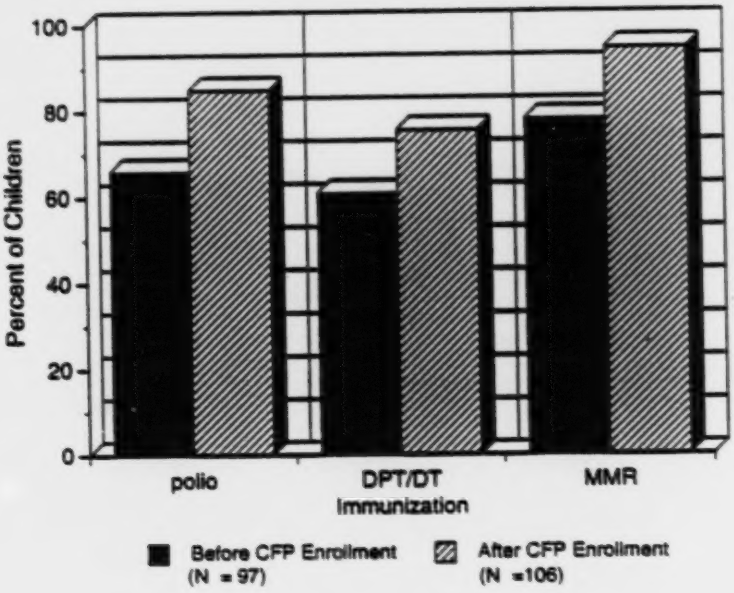
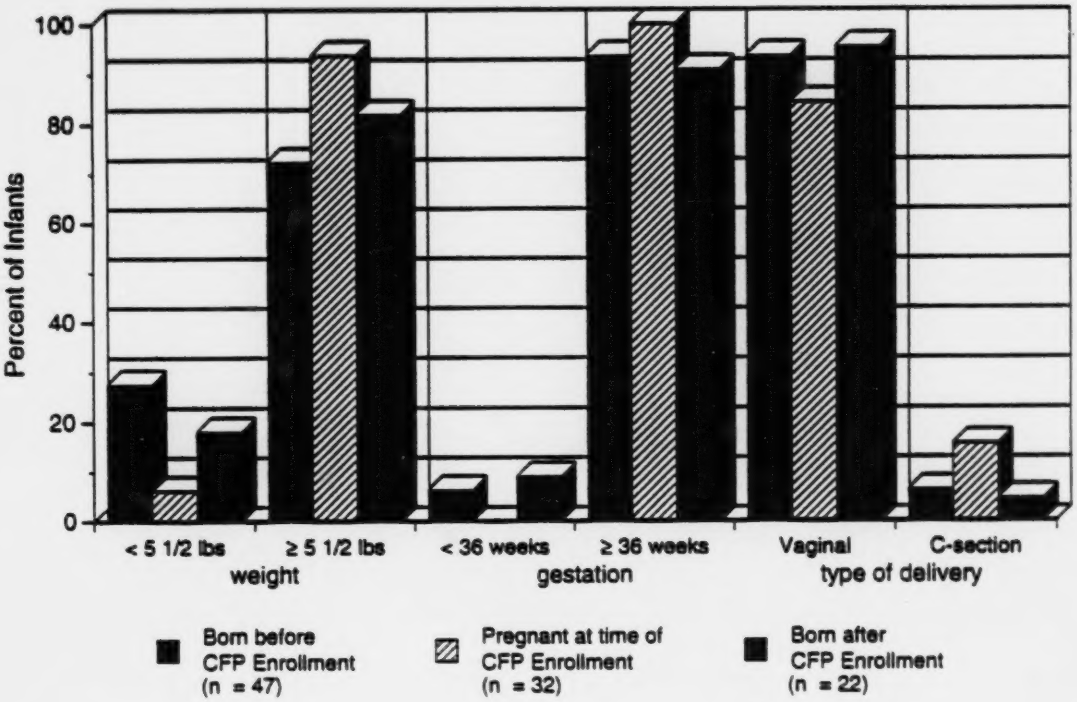


Figure 9

Birth Weight, Gestation, & Type of Delivery for Infants Born Before, at Time of & After Enrollment in CFP Project.



The Multicultural Child & Family Development Project (MCFDP): Evaluating the Development of Innovative Neighborhood Based Approaches for an Integrated Service Delivery System

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The Multicultural Child and Family Development Project at the Florida Mental Health Institute is described along with a review of some innovations to improve services and research.. Presented is a brief critique of the paradigm shift from agency-centered, pre-packaged service delivery to a neighborhood-based and community participatory system of care approach to human services. The staff of the Multicultural Child and Family Development Project (MCFDP) at the Florida Mental Health Institute have learned that this challenging task requires service agencies and researchers to change traditional ways of thinking and practice. Three models of program evaluation are reviewed and a community-based, culturally appropriate approach is presented for planning and evaluating services to ethnically diverse and low-income neighborhoods. While embracing elements such as ongoing process assessment and outcome measures, this project emphasizes the genuine partnership between professionals and community participants for integrative systems of care, and the ultimate goal of promoting the healthy growth of self-sufficient communities. It is the authors' contention that multi-level actions to promote strategies of prevention and self-sufficiency in the a neighborhood setting will foster positive mental health outcomes in immediate and long-term analysis.

Introduction

Meeting the needs of ethnically diverse and low-income populations through the development of community-based programs is both promising and challenging. This challenging task requires service agencies and researchers to alter traditional methods of service delivery. This paper presents one conceptualization of a culturally appropriate, community-based approach to systems of care, and some of the activities of the Multicultural Child and Family Development Project (MCFDP). The paper provides information on the initial program evaluation procedures which emphasized determining the needs of the population being served, and process evaluation measuring program implementation for subsequent program development. The framework for the program evaluation includes procedures and technical assistance provided to neighborhood programs to determine the impact of program intervention strategies on these target populations.

Background and Theoretical Issues

The vision of the essential components of the system of care outlined by Stroul and Friedman (1986) includes a comprehensive range of community-based and crisis services provided in appropriately least restrictive, normalized settings to meet the needs of targeted populations. Such services should be ecologically oriented based on available community resources as well as family and practitioner input. The concept of the system of care is a new and dynamic theoretical framework. At the stage of infancy in terms of conceptual development and actual implementation, existing models should be open to refinement and innovation (Duchnowski & Friedman, 1990). Despite the progress made during the 1980s in the field of children's mental health, and the shared general vision of an integrated system of care which is responsive to the needs of our culturally diverse population, much work is needed to actually develop and implement such a vision. It seems fair to assert that at the policy and system level, the agency-centered, individually-focused, prescriptive orientation still dominates the field of public human services.

Of great relevance to the development of a system of care in meeting the needs of ethnically diverse communities, is the involvement of practitioners in the facilitation of the planning, implementation and evaluation of community-based programs (Bastien, Coughlin & Daly, 1991). In addition, clients and their families should participate in treatment decisions (Bickman, Heflinger & Pion, 1991) in ways which enhance the system's effectiveness via sensitizing all stakeholders (Jordan & Hernandez, 1990) of necessary actions and resources. A community based approach is essential to the system of care concept as the neighborhood constitutes the most elemental eco-environment in which families and individuals are the building block.

The collaboration between practitioners, clients and their families, and other stakeholders is vital to strengthening and enhancing the neighborhood's capacity to serve as a healthy functional unit of the broader society. This section attempts to elaborate on the assumptions and essential aspects of the culturally appropriate, neighborhood-based, and participatory system of care approach to human services.

The fields of human services and social support are experiencing a dramatic and fundamental paradigm shift. Traditional approaches to social support and human services tend to be agency-based and package-oriented. The "client" is not expected to be able to make vital decisions about his/her problems and the family or persons within the neighborhood are rarely consulted on their real concerns and desires. Services are very often pre-packaged and "delivered" to neighborhood agencies whose responsibilities are directed to a contracting authority, not to the needs of the neighborhood. Using the individual client as the unit of behavior analysis and treatment, service agencies often ignore the social context of the client's life and the social dynamics of professional intervention, and hence, demonstrate harmful biases in the assessment of problems and in intervention strategies (Felton & Shinn, 1992).

Why reassess the "client-oriented" currently approaches in use by the human services community? Three reasons immediately appear relevant that justify a new orientation to be adopted for conducting research and planning services in contemporary communities: (1) the ineffectiveness of past programs for the populations served; (2) changing demographic characteristics (i.e., the increasing trend of ethnically diverse cultural groups residing within the same geographic areas); and (3) the acute nature of social issues, such as crime and environmental safety, which continue to impinge upon a community's capacity to provide quality life for its residents.

The Issue of Cultural Appropriateness of Interventions

Because ethnic or racial groups differ in their cultural values, norms, expectations, and attitudes (Marin, 1993), effective neighborhood change interventions need to be culturally appropriate and group-specific. The definitions of mental health and mental illness, for example, may be radically different among cultural groups. Ethnic minority populations are disproportionately labeled with the generally retractable diagnoses under the DSM-III-R system (Gynther, 1972; Lefley, 1986; Isaacs & Benjamin, 1991). By the same token, treatment or intervention strategies that are not culturally appropriate may be perceived by the target group as foreign, uncomfortable, ineffective, irrelevant, or immoral. There are deficiencies in both utilization of services and satisfaction with services accompanied by a high rate of voluntary withdrawal from treatment by minority groups (Sue, Fujino, Hu, et al., 1991; O'Sullivan, Peterson, Cox, et al., 1989).

Culturally appropriate community interventions should meet all three of the following principles as outlined by Marin (1993): (1) the intervention is based on the cultural values of the group; (2) the strategies that make up the intervention reflect the attitudes, expectations, and norms of the group; and (3) the components that make up the strategies reflect the behavioral preferences and expectations of the group's members. In this context, it is critical to develop innovative strategies for the implementation of more effective systems of care that not only serve the needs of those with urgent problems, but also eliminate the conditions that place children at risk. A culturally sensitive, neighborhood-based system of care is a very promising approach for achieving these objectives.

The Issue of Neighborhood-based Interventions

It appears that a side effect of what McKnight (1987) refers to as a dependent "service system consumer" relationship characteristic of urban neighborhoods has contributed to the weakening of communities. On the one hand, there is an overly "professionalized" community of service providers, while on the other hand, there exists a grassroots community composed of families and individuals capable of exercising creative energy, insight and reason in solving their problems given the experiential connectedness felt toward their community.

According to McKnight (1987), the resulting problems with overly professionalized service programs include a tendency to create a cycle of dependency among the targets of intervention they purport to assist and minimal emphasis on primary prevention measures at the community level. According to Cowen (1983, p.15), primary prevention at the community level must be: (1) oriented toward the masses rather than to targeted individuals to avoid labels and associated stigmas, since ethnically diverse cultural groups have different sets of values, beliefs and coping strategies from that of mainstream America (Marin, 1993; Naparstek, Biegel & Spiro, 1982) and are often suspect of service agencies (Cross, Bazron, Dennis & Isaacs, 1989); (2) directed to essentially "well" people, not the already affected; and (3) operated in an "intentional" manner that strengthens psychosocial health or that reduces noxious stimuli from the neighborhood environment, thus protecting the residents.

A culturally competent innovative approach to the development and evaluation of neighborhood-based systems of care requires that program developers and researchers have a genuine understanding of the real needs of a community, that the community be an active participant throughout the process of program conception and implementation. Strategic planning is an essential aspect of such an approach which necessarily begins with an assessment of the environment and the concerns of the neighborhood (Cross et al. 1989). Community needs assessment is crucial for identifying unmet needs and available resources in order to plan appropriate and effective programs for the specific neighborhoods (Rhodes & Jasons (1991).

As a way to encourage the participation of the collective community, Costa-Marti & Serrano-Garcia (1983) propose a needs assessment approach which calls for the creation of a core group composed of both key community persons and interveners. The core group is responsible for planning, coordination and evaluation throughout the entire process of intervention. The core group will direct and coordinate the needs assessment by evaluating the relevance of the different needs assessment techniques to their given community.

Program Evaluation Models Examined

Three innovative research approaches which evaluate systems of care for children and adolescents are presented in this section: The Boys Town Family Home Program Comprehensive Evaluation System (Bastien, Coughlin & Daly, 1991); the model utilized by Bickman, Heflinger and Pion (1991, 1992) for evaluating the Ft. Bragg Child & Adolescent Mental Health Demonstration Project, and the Ventura Planning Model (Jordan & Hernandez, 1990). These models confirm that services, evaluation, and research can co-exist and closely exemplify the authors' conception for evaluating neighborhood-based, culturally competent systems of care.

Boys Town Family Home Program Comprehensive Evaluation System.

The Boys Town Family Home Program (Bastien, Coughlin & Daly, 1991) is patterned after the University of Kansas Teaching Family Model (Phillips, 1968). This comprehensive evaluation system emerged from the impetus to provide the best quality care possible and the Boys Town administration's recognition that a reliable data-base was an essential tool to enhance positive program outcomes of youth care and treatment. The periodic reports collected over the 15 year longitudinal study period resulted in the development of an elaborate management information system. The evaluation approach consisted of three systems of evaluation that evolved sequentially according to stages of program development. The three evaluation systems include process evaluation, short term outcome evaluation, and long term outcome evaluation. The central goal of the three levels of evaluation was to capture information that could be utilized to refine the program and, hence, the quality of care.

Ft. Bragg Demonstration Project Evaluation.

The Ft. Bragg Child and Adolescent Mental Health Demonstration Project (Bickman, Heflinger & Pion, 1991 and Bickman, Heflinger, Pion, Behar (1992) addresses four critical evaluation issues: process of implementation; quality of services; outcome of mental health interventions; and analysis of costs. The data collected from the evaluation of the implementation process are used to correct structural and operational problems as well as to serve as guidelines in replicating the project. Client services records and files, reports by persons interacting with the client, peer review of treatment provided, and direct observation are means for assessing the degree to which program implementation and program conceptualization-design are aligned. Bickman et al. (1990) proposed that in evaluating service quality, an informative or explanatory level of data must precede the component level prior to measuring the occurrence, intensity and appropriateness of an activity. Quality assessment was the approach proposed to monitor and validate the evaluation and to assess the quality of essential service components. The rationale behind adopting a quality assessment approach surrounded the issue that there existed scarce descriptive literature on interventions influencing mental health and that in order to measure quality, a full description of the actual treatment must first be obtained. The Ft. Bragg Demonstration evaluation attempts to systematically describe the operations involved in service provision.

The Ventura Systems Monitoring and Evaluation Model.

The success behind Ventura County's Children's Demonstration Project (Jordan & Hernandez, 1990) is no doubt indebted to the comprehensive planning process which evolved in a circular fashion – i.e., the development of services lead to the project's conceptual development, resulting in continual service development with implications for further conceptual refinement. The project contrasts with the Bickman et al. (1991) component approach of evaluation in that the planning process contained a feedback feature which permitted the system of care to renovate itself over time according to newly identified needs for specific types of services. Built into the planning process was a two-part evaluation system: a system-monitoring mechanism for providing an internal feedback loop to sensitize staff and the administration of project progress, and a client outcome profile for informing external agencies of the cost-effectiveness of their expenditures.

As distinct as the evaluation models may appear, they share some underlying characteristics. For starters, all rely on formative or process evaluation techniques wherein assessment mechanisms are built into the system from the early stages of the planning process. The primary goal of the evaluation process entails capturing reliable data at cross-sections of time which serve to refine services proactively in contrast to the reactive approach of "discovery and removal of the bad apples" illustrative of normative evaluations (Bickman, Heflinger & Pion, 1991, p. 55). The feedback process enables continual service adaptation around recipient needs. All involve mechanisms which operate to identify weaknesses within the system such as gaps, duplications, and inadequacies of services that must be corrected not only to guarantee quality and effectiveness of service provision, but also to ensure cost containment. An informative system of that nature permits limited resources to be recaptured and shifted to those domains most critically in need. Such a feature of internal revisions, checks and balances of resources has implications to sustain and rebuild the system of care which seeks to be integrated and coordinated.

The Multicultural Child and Family Development Project (MCFDP).

Missing from the three models discussed above is grass-roots community participation in planning, implementing, and evaluating the programs. This participation is essential for a community-based system of care approach. Unlike programs that take an agency-based, top-down approach to services and concentrate on the most disturbed individuals, MCFDP seeks to facilitate the eventual adoption of a primary or preventive system of care, not solely by the service community, but by the neighborhood itself. It is our contention that if we assist community organizations to improve program development, then an increase in the effectiveness of programs for ethnic minority families will follow suit.

The rationale behind MCFDP's activities is that neighborhood programs will function at an optimal level of efficiency and therefore achieve the goals of delivering effective services to the community when provided with technical support to strengthen performance. For instance, the MCFDP participated in program meetings and activities in order to observe and document the process of decision making and consensus building which typically occurred in organizational settings. Other examples of assistance provided by MCFDP staff to neighborhood programs include reviewing program documents, actively participating and observing project activities, conducting unstructured interviews with project participants, and developing profiles of project participants for program evaluation purposes. The MCFDP staff subsequently took measures to intervene in deficient areas of organization activities, such as preparing meeting minutes and agendas, sign up rosters, and registration forms. As minor as these measures of technical support may appear, they facilitated the organization and flow of meetings so that efforts could be geared toward constructive projects.

What follows is an overview of MCFDP activities. Three case studies serve to illustrate the approach utilized by the authors in evaluating the development of a system of care in ethnically diverse neighborhoods. The MCFDP staff provided technical assistance to several community agencies in Hillsborough County, Florida, including the East Tampa

School Community Partnership (ETSCP) at the Lee Davis Neighborhood Service Center, the Home Instructional Program for Preschool Youngsters (HIPPY), and two community development projects for the Tampa Housing Authority.

East Tampa School Community Partnership (ETSCP).

The ETSCP was created in 1990 to improve neighborhood relations with the public schools. This neighborhood-based program serves an ethnic minority community (87% African American) comprising what is known as the East Tampa neighborhood. The ETSCP is designed to provide families with skills to enhance their educational involvement with the school system and with their child's academic achievement and social competence. The partnership group is comprised of a network of concerned citizens, i.e., parents, school representatives, social service agencies, and community representatives. Our staff obtained baseline data, the initial step in a continuing process of evaluating ETSCP's services to families, and reporting to decision makers on a regular and timely schedule. The evaluations are beneficial to the community, school system, and to program participants in providing information on the nature or effectiveness of the services being received. Feedback from this type of data will allow ETSCP and the school system to change procedures which are inconsistent with program objectives. One area in which MCFDP's assistance improved overall program functioning was in keeping an attendance roster to develop a mailing label system to facilitate meetings. The rationale for this was that there were no previous means to monitor which individuals and agencies were attending meetings. An increase in attendance resulted after the mailing label system was implemented. Preliminary findings show a doubling in ETSCP committee meeting attendance from 1991 to 1992 and increased participation by public schools. Several surveys were developed to determine the satisfaction levels of agency staff, family members, and school staff with various project activities, programs, workshops and training activities. On the average all participants were strongly satisfied with the efforts of the ETSCP and found that the project improved parent and school involvement.

Home Instructional Program for Preschool Youngsters (HIPPY)

HIPPY is a home-based program for the educational enrichment of disadvantaged preschool children. The program seeks to allow mothers to recognize their own strengths and potentials as home educators. When MCFDP staff became involved in the HIPPY program in 1991, no evaluation had been conducted. An initial evaluation of 1990-91 data yielded inadequate and unreliable data due to a lack of response by parents. HIPPY staff was experiencing difficulty in collecting the required forms. When forms were returned for data collection, a certain number of forms were not turned in on time, were not complete, and were incorrect. A preliminary analysis of the 1992-93 HIPPY forms showed a 95% response rate, a significant jump from the 1990-91 baseline data. The information from the forms is currently being used to collect demographic data, determine lessons being completed by families, staff contacts with families, parent participation in parenting classes and staff training activities with families. Evaluation of the HIPPY Program is now ongoing as a result of MCFDP's input in organizing and revising forms for meetings with parent educators. Consumer satisfaction surveys and video taping of parents conducting lessons with the child were collected to assess how much parents gained from the program. The research team built a positive relationship with the parents and came to be viewed as an essential component of the program.

Youth Sports and Cultural Programs (YSCP)

The YSCP is a project sponsored by the Tampa Housing Authority to counter violence and crime near public housing. Through a variety of educational, cultural, health and fitness, sports, career exploration, outreach and prevention services, YSCP aims to enhance the psychosocial development of youth by building self-esteem and self-image. The MCFDP presently is conducting an initial needs assessment (a clarification of the program goals and objectives); a demographic survey obtained from the program records, participants, staff and community indexes; and service satisfaction measures. The overall aim of MCFDP's evaluation is to link services to the expected program outcomes and to monitor individual youth achievement.

Conclusion

With community members as critical participants and equal partners in planning , implementing, and evaluating culturally appropriate and neighborhood-based system of care, program evaluators and researchers need to adopt a role quite different from the traditional one. We can no longer comfortably design our experimental research in our offices, collect data, publish reports, and then turn our back to the community. We need to learn our new role as partners, facilitators, and yes, learners.

The conceptual tools provided will assist in efforts to foster a true partnership among service providers, community leaders, and residents. The core of the conceptual framework we are attempting to develop must include collaborative vigor and equal input among:

- the institutions (programs/ agencies providing services and technical assistance);
- collective community (informal and formal organizations); and
- individual families and citizens.

This triad of stakeholders will show greater success in envisioning the needs and wants of the community, and in organizing the delivery of services necessary to foster healthy communities and families.

The challenge for a system of care now rests on developing sound approaches to attract maximal public participation that will insure neighborhood input and values throughout the entire planning, development and evaluation process. Due to the evidence provided in the research literature and first hand experiences of MCFDP, we advocate the adoption of the innovative system of care approach to meet the challenges of working with culturally and ethnically diverse communities.

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The Organization, Staffing and Financing of Systems of Care

Chapter 2

State Financing Strategies to Promote Home and Community-Based Services for Children with Serious Emotional Disturbances and Their Families.

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Introduction

Children with serious emotional problems, their families, and the services provided to them have received a marked increase in attention since the mid-1980's. Led by the Child and Adolescent Service System (CASSP) program of the National Institute of Mental Health (NIMH), a new vision of service provision for children and adolescents and their families emerged (Friedman & Kutash, 1992). This vision emphasized the need to develop community-based systems of care based on a set of values and principles and the best available research. These systems of care, which have been implemented intermittently across the country, incorporate a range of services; involve several agencies; forge new partnerships between parents and professionals; and provide intensive, individualized, and culturally-competent services. These systems are based on the belief that parents should be supported in their efforts to keep families intact, that services should be provided in the least restrictive setting that is appropriate to meet a child's needs, and that through flexible and individualized services it is possible to reduce an over-reliance on out-of-home placements.

Despite this increased focus, there remains a discrepancy between the conceptual model of what a system of care should be, as embraced by policy makers, and its actual implementation at a grass-roots level. One of the challenges facing the field of children's mental health is the financing and funding strategies used by state governments to implement the principles of home and community-based systems of care for children (Wolf, 1991).

The importance of the financing systems for services for children and their families was emphasized in congressional testimony by Lenard Saxe, senior author of the U.S. OTA report. Saxe (1987) indicates that, "The reason for the present inefficient and ineffective system are many, but one is increasingly central: Our methods for paying for mental health care. Rather than children's needs being paramount in deciding whether and what type of treatment will be proffered, treatment decisions are increasingly driven by the health care reimbursement system. This system ... is neither successful in controlling costs or in providing adequate services." According to Dickey and Cohen (1991), the goal of community-based service provision will be most affected by financial incentives.

Historically, public care of children with serious emotional disturbances has been the responsibility of state government (Dickey & Cohen, 1991). State government continues to control most of the expenditures for the delivery of mental health services with state general revenue funds representing 83% of the state controlled funds received by community-based programs (National Association of State Mental Health Directors and the National Association of State Mental Health Program Directors Research Institute, 1990). In addition to being the fiscal agent for the majority of mental health services to children and adolescents, the state is also responsible for the major policies and procedures surrounding the reimbursement of costs for mental health services. It is often these policies that promote restrictive settings for the care of children rather than alternative community-based care. An example of such a policy involves the payment of admissions to state run institutions, such as state hospitals. Some state governments have policies stating that the cost of admissions to state hospitals are absorbed at the state level and are "free" to referring communities. This policy, therefore, creates a fiscal incentive for local communities to refer to a restrictive hospital placement rather than a less restrictive community-based alternative.

Several solutions and fiscal principles have been suggested to overcome the fiscal barriers to community-based care for children and adolescents. These include: creating a state/local partnership on the allocation of revenue used for admissions to state hospitals; policies that encourage flexible funding (pooling of funds between agencies, decategorization of funding streams, and wraparound funds) which meet the need of youth rather than the guidelines of a child serving agency; using federal funds (such as Medicaid) to promote community-based care; and state provision of fiscal incentives for the development of community-based care.

The purpose of this study was to 1) document whether the fiscal principles and solutions being suggested in the literature are

Table 1

Financial Principles

☐ State financial policies should include a state/local partnership on the allocation of revenue used for state hospital admissions.

☐ State financial policies should encourage flexible funding (pooling, decategorization, and wraparound funding) of services for children.

☐ State policies should encourage the use of Federal funds (such as Medicaid) to enhance home and community-based services.

☐ State plans should provide financial resources and incentives for the development of community-based services.

☐ State financial policies should provide a balance/appropriate mix of services to provide for the needs of all children.

thought of as viable by state policy makers (see Table 1 for a listing of the financial principles); 2) to investigate and describe if the financial mechanisms contained within the principle are being used in state government; 3) to describe the extent of the use of the fiscal policies and procedures to promote community-based care in state government in the United States; and 4) to explore whether the structure and organization of local mental health authorities within a state are associated with the use of policies and procedures to promote community-based care for youth.

Method

Subjects

Respondents were 50 state directors of children's mental health services whose names were obtained from a membership roster of the State Mental Health Representatives for Children and Youth (SMHRCY) Association or a delegate of their choice.

Instrument

Following a review of the literature, a telephone survey was designed to gather information regarding a state's level of agreement with various financial principles with a scale ranging from 1 "strongly disagree" to 5 "strongly agree". Information was also gathered regarding the extent to which financial policies and procedures are currently being used in the state to maximize community-based mental health services for children and youth with severe emotional disturbances and their families with a scale ranging from 1 "no use of policies and procedures" to 5 "statewide use of policies and procedures". Questions covered the following areas: financial partnerships between local communities and state governments for the cost of state hospital admissions; flexible funding of services for children; the use of federal funds such as Medicaid to enhance community-based services; state-provided financial resources and/or incentives for the development of community-based services; the provision of "balanced" care to all children in need; formulas used to allocate state monies to local communities for community-based services; the organization of local mental health administrations; and any additional mechanisms utilized to create financial incentives encouraging the development of community-based care.

Procedure

Field Testing. A telephone interview was conducted with eight state directors of children's mental health services selected for field testing of the instrument. The survey was revised based upon the responses and recommendations of those respondents.

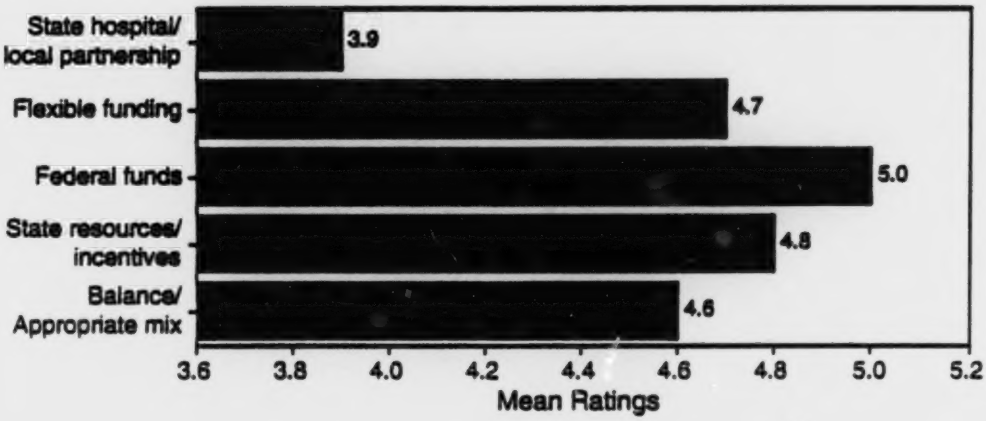
Data Collection. Survey instruments were mailed to each of the 50 respondents. A trained interviewer conducted the survey by phone and mailed the recorded responses to the respondent for their review and validation. To increase the accuracy of a state's response, a copy of the documented responses was also forwarded to the Director/Commissioner of the State Government Mental Health Program for each state. Upon return, responses to the validated survey were entered into a computer database.

Results

Surveys were completed by representatives from 50 states. Representatives from the District of Columbia and the four U.S. territories (America Samoa, Puerto Rico, Virgin Islands, and Guam) were surveyed; however, due to their unique forms of government, their responses are not included in this summary.

Level of Agreement with Financial Principles. Figure 1 shows the average ratings of agreement with the 5 financial principles with higher ratings indicating greater agreement with the statement or principle. As can be seen, the majority of the respondents either agreed or strongly agreed with the principles. In fact, for three of the five principles, "agree" and "strongly agree" were the only ratings chosen by the

Figure 1
Mean Ratings on Agreement with Financial Principles



respondents. The three principles covered the areas of flexible funding of services, federal funds/Medicaid, and state provided resources and incentives for the development of community-based care. The lowest rated principle was in the area of a state/local fiscal partnership for the costs of admissions to state hospitals. While still in the range of agreement, this principle resulted in the most variability. For example, one respondent stated that their rural, poor areas of the state were unable to be fiscal partners, while another respondent disagreed with the principle because he felt the entire cost of admissions to state hospitals should be born by the local communities. The highest rated principle was in the area of using federal funds, such as Medicaid, to promote community-based care.

Level of use of financial mechanisms to promote community-based care. Each respondent was questioned if the mechanism mentioned in each principle was in use in their state. In addition, the extent of use or implementation of each financial mechanism was also asked, i.e. was the mechanism in use on a statewide basis, for most of the state, in a few areas of the state, in the planning stage, or not in use at all in the state. Figure 2 shows the responses to the financial mechanism of creating a state/local partnership in the cost of admissions to state hospitals. As can be seen, eight states reported either having no state hospitals or not utilizing state hospitals for the provision of services to children and adolescents. Only 10 states reported having this fiscal mechanism in place and 32 states were reported as not having a state/local partnership for admissions to state hospital or have plans to develop such a partnership. Figure 3 and Table 2 show the frequency of states using the remaining principles either state wide, in most areas of the state, or in a few areas of the state. With regard to the mechanism of flexible funding, 23 states report using the pooling of funds between child serving agencies, 18 states report the decategorization of funding streams, and 30 report the use of wraparound funds. Thirty-eight states use federal funds, such as Medicaid, and 33 states report using state provided resources and incentives to provide community-based services for children and youth.

The responses to the extent of use for each of the six financial mechanisms were summed and averaged for each state. This total implementation score ranged from a high of 30, indicating that a state is using each of the mechanisms on a statewide basis, to a low of 6, indicating that none of the mechanisms were implemented in the state. Three states (California, Kansas, and Wisconsin) report using all six of the mechanisms, to some extent, in their states. This total increases to 5 states (Kentucky and Vermont) when the first mechanism for states that do not have or do not use state hospitals for youth is eliminated (Figure 3A).

Figure 2
Frequencies of State/Local Partnerships on State Hospital Use

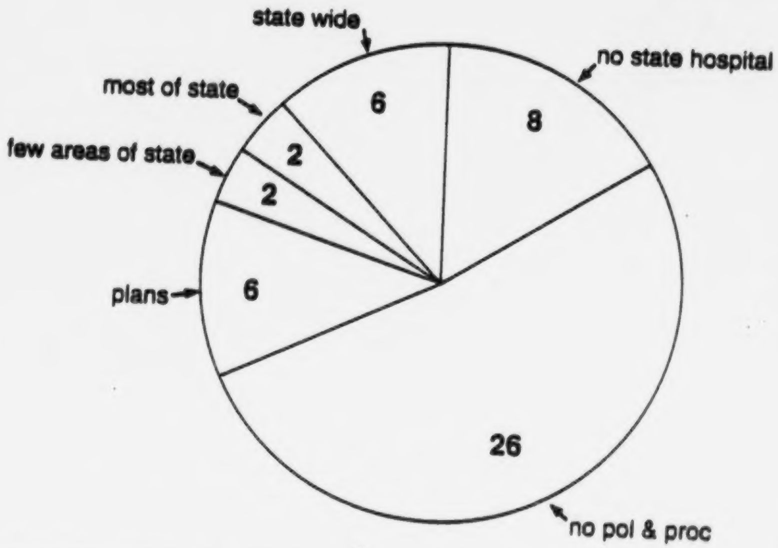
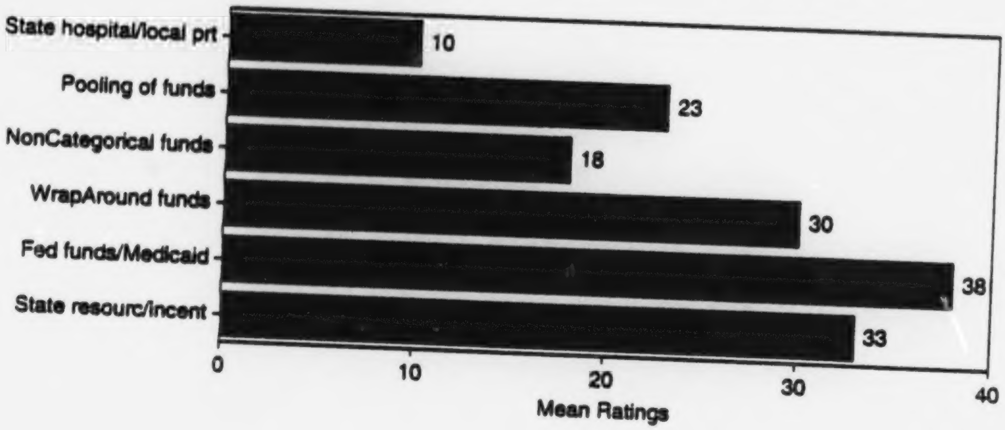


Figure 3
Number of States Using Financial Mechanisms to Any Extent



Note. *N* = 42 for first mechanism because no state hospitals in 8 states.

Table 2
Extent of Use of the Community-Based Financial Mechanisms

	No policies/ procedures	*Plans to develop*	*A few areas*	*Most of state*	*Statewide*
State/local partnerships (*N* = 42)	26	6	2	2	6
Flexible Funding:					
Pooling	12	15	10	1	12
Noncategorical	12	20	8	1	9
Wraparound	3	17	12	1	17
Federal Funding/ Medicaid	4	8	8	3	27
State resources/ incentives	5	12	10	6	17

Structure and organization of local mental health authorities.

Respondents were also asked to describe the structure and organization of the local mental health authority in their state. Six respondents reported that their state had no local mental health authority. In these states, all mental health services are administered and delivered by the state. Table 3 depicts the frequencies of the types of organization for local mental health authorities. Community mental health centers are the most

Figure 3A
Number of States by Total Implementation Score

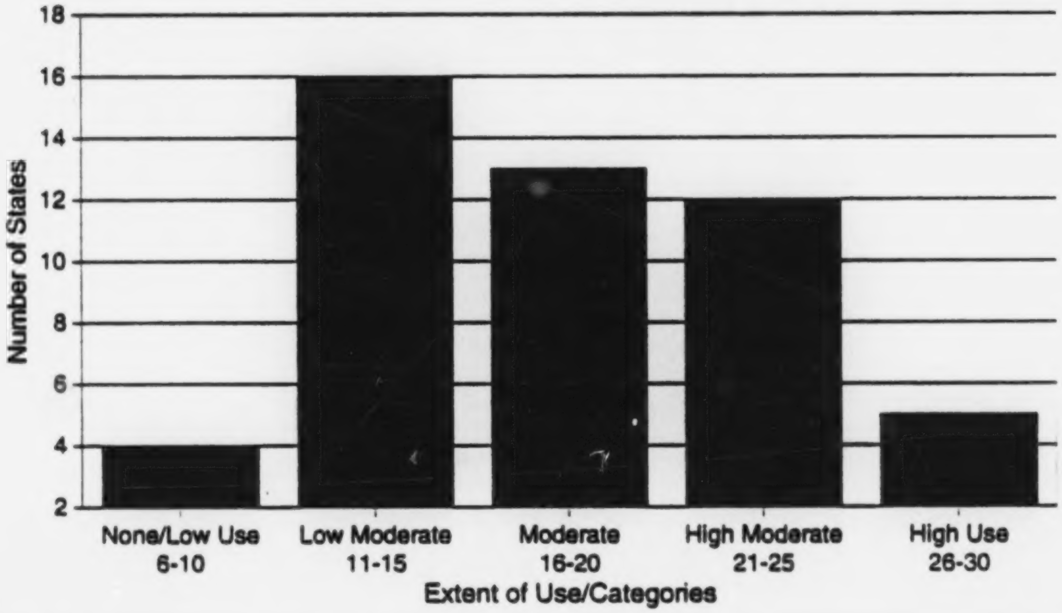


Table 3
Types of Organization for Local Mental Health Administrations

Type of Organization	*Frequency*	*Mean Extent of Use (SD)*	
		Raw	*Standardized*
CMHC	25 (50%)	16.17 (5.8)	-1.04 (3.8)
Dist/Brds	11 (22%)	20.22 (4.4)	1.59 (3.1)
Loc govt agency	8 (16%)	21.25 (3.7)	2.18 (2.6)
State Admin.	6 (12%)	15.43 (5.5)	-1.46 (4.1)
Total	50 (100%)	17.78 (5.6)	0.00 (3.7)

frequently reported local authority with 25 states reporting this type of structure. The next most frequently reported structure was local districts or boards (11 states) followed by local government agencies reported for 8 states. The average total scores for extent of use of the financial mechanisms for each type of structure and organization was compared and is shown in Table 3. States with community mental health centers serving as their local mental health authorities had a statistically lower use of the financial mechanisms than did states with local districts/boards or states with local government agencies. This implies that local mental health authorities that are organized within a strong local form of government may have greater flexibility to create financial mechanisms that promote the use of community-based care. While the mean score for states having no local mental health authorities appears to be the lowest, due to the few number of states, it was not statistically significantly different from the other categories. Interestingly, these same states also had the overall lowest agreement with the financial principles.

In summary, Figure 4 illustrates that while the agreement with the five financing principles was very high, the implementation of these principles was not as consistent, with only 5 states implementing the mechanisms described to some extent in their states.

Conclusion

In conclusion, one purpose of this study was to determine whether there was agreement among policy-makers with the financial mechanisms that have been promoted in the literature to increase the availability of community-based care for children with severe emotional disturbances and their families. The ratings from state level policy-makers revealed an overall consensus with the financial principles presented, indicating the applicability of these financial principles. However, when the implementation of the financial mechanisms corresponding to the principles was reviewed, the results were not as consistent. Only five states reported implementation of each of the financial mechanisms in their states to some extent. The most frequently used financial mechanism, as reported by 38 states, was the use of federal funds such as Medicaid to promote community-based care.

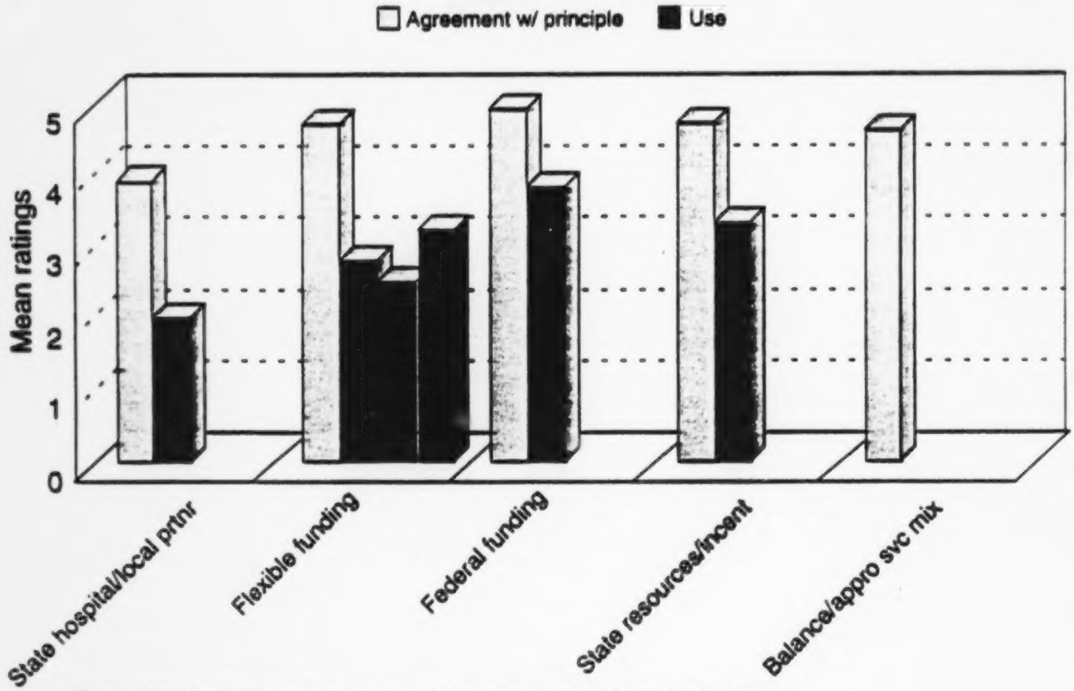
Another purpose of this study was to explore whether a relationship existed between the structure and organization of local mental health authorities and the implementation of financial mechanisms to promote community-based care in a state. It appears that states having a strong form of government at the local level have implemented a greater number of the financial mechanisms to promote community-based care than those states which are centralized or use community mental health centers as the local authority for mental health services for children and adolescents.

It should be noted, however, that this study has several limitations. The principles posed for agreement or disagreement may have been worded in such a way as to bias the respondent to answer toward agreement. The financial principles were posed in a very broad nature. One respondent stated that being opposed to these principles would be similar to being opposed to "mom and apple pie". Also, this study used only one respondent for completion of the survey. While the completed survey was to be reviewed by a state commissioner for mental health, there was no objective review of the ratings for implementation by someone outside of the state. Therefore, the results of the implementation of these financial mechanisms may be biased by the respondents attempts to describe their states in the "best light". In addition, while terms such as "decategorization of funding streams" were defined in the questionnaire, interpretation of such terms may have varied between respondents.

Another limitation is that the researchers used a liberal criteria for the endorsement of using a financial mechanism in a state. If a respondent reported that a mechanism was being used, even on a pilot basis in a limited section of the state, it was considered being implemented in a state. This definition of "use" may have artificially increased the frequencies in this study.

Given the limitations stated above, this study has begun to document the extent to which the financial mechanisms described are being implemented to promote community-based care for youth with serious emotional disturbances and their families. While this study may provide a "baseline" examination of the use of these financial mechanisms, there is a need for further exploration in this area. The impediments to

Figure 4
Summary of Results



"Extent of use" for first principle based on *N* = 42 because 8 states had no state hospitals.

implementation of financial mechanisms that promote such care need to be explored. This study suggests that the structure and organization of local mental health authorities may promote the use of such mechanisms, thus providing yet another area for further study.

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Staffing Systems of Care for Children and Families: Workforce Issues Related to Community-Based Service Delivery for Children and Adolescents with Serious Emotional Disturbance and Their Families

This paper describes the results of a regional needs assessment of workforce issues related to implementing systems of care for children with serious emotional disturbance and their families. The assessment was conducted for the Southern Human Resource Development Consortium for Mental Health, a coalition of 12 southern states, by Human Service Collaborative, with input from the CASSP Technical Assistance Center. Results are based on a survey of key stakeholders in the region, including parents, state mental health officials, local providers, advocates and others. The survey sought to identify the priorities of public child mental health systems over the next five years and the implications of these future directions for the children's workforce. The survey addressed issues related to recruitment and retention, staff distribution and utilization, staffing requirements for community-based services, preservice and in-service training, state capacity to address workforce issues, and state-university linkages.

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Background

The implications for the workforce of the developments in the child mental health field over the last decade are enormous (Behar, 1985; Pires, 1991; National Institute of Mental Health, 1992):

- The types of community-based services included in most state plans today, such as therapeutic foster care, in-home services, "wraparound" services, respite and crisis services, involve new, still-evolving technologies in which the vast majority of staff have not been trained. Indeed, with many of the new technologies, there is continuing experimentation with what staffing patterns ought to look like.
- The interagency collaboration and service integration called for in most state plans today are complex, involving staff from multiple systems with different mandates, financing streams, training and orientation.
- Meaningful involvement of families often requires staff both to acquire new skills and change existing attitudes. Families themselves need training to be effective participants in systems of care, including functioning in staff roles.

- Few staff have been trained in cultural competencies.
- Many state plans encompass both children with serious emotional disorders, as well as those at risk. Staff thus must have the capacity to understand a wide spectrum of disorders, as well as risk factors.
- Many state plans emphasize the importance of early intervention services for infants and toddlers, ages birth to 3, as well as transition services for young adults, ages 18 to 22. Thus, staff capacity must cover a broad developmental range.
- The infrastructure to implement community-based systems of care requires major adjustments in management information systems, financing and other central support structures, which pose challenges for managers and administrative support staff.
- Over the past decade, there has been some formal documentation and much anecdotal corroboration that academic curricula and practica across all of the disciplines are not keeping pace with developments in public service systems for children and families (Kravitz, 1991). Too often, the academic preparation of those entering child-serving systems has failed to give them the knowledge, skills or attitudes needed to implement effective community-based systems of care.

Assessment of workforce issues is a critical step in the implementation of community-based systems of care. This paper describes the results of a regional needs assessment of workforce issues related to the delivery of community-based services for children and adolescents with serious emotional disturbance and their families. The assessment was conducted for the Southern Human Resource Development Consortium for Mental Health, a coalition of 12 southern states, by Human Service Collaborative, a research and consulting group specializing in children's systems, with input from the Child and Adolescent Service System Program (CASSP) Technical Assistance Center at Georgetown University.

Method

The principle instrument used for the needs assessment was a written survey. The survey sought to identify the priorities of state child mental health systems over the next five years and the implications of these future directions for the children's workforce. The survey addressed workforce issues related to recruitment and retention, staff distribution and utilization, staffing requirements for community-based children's services, pre-service and in-service training, state capacity to address workforce issues and state-university linkages related to workforce concerns. The survey also sought to identify strategies in the region that address workforce issues.

All of the survey questions addressed themselves to service and HRD issues in the public child mental health system. "Public mental health system" was defined to include both publicly operated programs and services, as well as private programs with which the public sector may contract. Respondents were asked to include in their answers HRD issues affecting both publicly operated programs as well as private agencies providing services on behalf of the public system.

Most survey questions required respondents to check relevant answers from a list and then rank the top three. All sections also included open-ended questions to identify other relevant issues, as well as strategies.

In February 1991, the survey was mailed first class, with a stamped return envelope, to 84 key informants in 11 of the 12 states that are members of the Southern HRD Consortium. Key informants were identified by State Mental Health Commissioners and HRD managers in each of the states in the region, at the request of the Southern HRD Consortium. Those identified to receive the survey included: parents of children and adolescents with emotional disturbance/mental illness; state mental health commissioners; HRD managers; state mental health representatives for children and youth (SMHRCY); CASSP directors; other state mental health agency officials; local service providers (public and private); state legislators; university representatives; representatives from other child-serving systems, such as child welfare and education; and, state and local advocates. The four largest categories of key informants were: local mental health service providers (public and private); state mental health agency officials; parents; and, advocates.

Copies of the survey also were sent to key individuals at the national level to encourage their interest and assistance in maximizing response to the survey.

Several rounds of follow-up telephone calls were made to all those who received the survey to ensure receipt and understanding of the survey and to encourage response. Surveys were returned during the period, March - June, 1992, and analyzed during June-August, 1992.

Forty-nine of eighty-four surveys – or 58% – were returned. The survey was analyzed by region, by each state within the region and by the four major respondent groups (i.e., parents, state mental health agency officials, local providers and advocates).

Results

- The *major directions* in which state child mental health systems in the region are heading over the next five years are:
    - development of more and new types of community-based services (identified by 94% of respondents)
    - joint initiatives between child mental health and other child-serving systems, particularly the child welfare system (identified by 88%)
    - development of new financing mechanisms (identified by 80%)
    - development of state and local level coordinating bodies (identified by 73%)
    - development of family advocacy and support programs (identified by 69%)
    - development of culturally competent services (identified by 65%).
- The *new types of community-based services* states are developing are:
    - therapeutic foster care or family treatment homes (identified by 82% of respondents)
    - in-home services, either crisis or longer term (identified by 78%)
    - day treatment or psycho-educational programs (identified by 73%)
    - therapeutic group homes (identified by 73%)
    - intensive case management services (identified by 69%)
    - crisis intervention services (identified by 67%)
    - respite services (identified by 67%)
    - community-based residential treatment centers (identified by 65%).
- *The majority of respondents region-wide either do not know or do not believe there is adequate knowledge in their respective states about staffing requirements* for implementing community-based services for children, including knowledge about the numbers of staff needed, the skills that are required, the types of staff needed, the mix of staff and staff distribution requirements.
- *80% of those surveyed do not believe their states have access to sufficient numbers of staff* to implement community-based services for children. The top ranked reasons are: *insufficient funding to hire staff; insufficient numbers of persons being trained; and, too few who are trained are entering the public system.*

- Those surveyed believe staff shortages exist in every discipline, and types of shortages vary across states. Majority (or greater) consensus on the most critical shortage areas occurs only with respect to child psychiatry. Regional consensus on the next most critical shortage area drops to 20%; those areas are *parents in staff roles* and *psychiatrists. 65% of respondents could identify no strategies in their respective states to address staff shortages.*
- *76% of those surveyed do not believe their states have access to adequately prepared staff* to implement community-based services for children. Respondents believe this is especially a problem in three major areas: *working with families; understanding emotional disturbance in children and adolescents; and, understanding and having the skills to implement the newer community-based service technologies.*
- *Respondents believe lack of adequate preparation and training is a problem with all disciplines.* Most frequently cited as least prepared are: mental health technicians, special educators, and child psychiatrists. Most frequently cited as most prepared are MSWs and Ph.D. psychologists (by 18%; however, 20% also cite MSWs and psychologists as least prepared).
- *71% believe that the major reason staff are not adequately prepared is because university curricula are not relevant to state priority areas.* The next most highly ranked reasons are: *limited faculty exposure to and understanding of state priority areas; child mental health system reliance on staff from the adult mental health system who are not trained in the children's area; and, insufficient opportunities for students to do practica and internships in the public child mental health system.*
- *Respondents rank highly (8 to 10 on a scale of 1 to 10) the need for in-service training to improve staff skills.* The most frequently cited new skills that are needed are: *working with families; understanding the newer community-based service technologies and the system of care concept; interagency competencies; appropriate use of behavior management; and, cultural competency.*
- *The majority also rank highly (7 to 10 on a scale of 1 to 10) the need for in-service training because of inappropriate staff attitudes.* 80% of parents rank this a "10" on a scale of 1 to 10, as do 71% of state agency officials, but only 38% of local providers give it this high a ranking. The areas most frequently cited where staff attitudes are an issue are: *working with families; resistance to interagency collaboration; over reliance on hospitalization or traditional, clinic-based psychotherapy; and lack of cultural awareness.*
- A majority of respondents indicate that appropriate *in-service training curricula, methods and personnel are not available* in their respective states due, primarily, to *lack of funding.* Major portions of curricula *are* available throughout the region but not necessarily implemented. *61% of respondents overall rank the extent that states are conducting in-service training at 5 or below on a scale of 1(none) to 10 (extensive).*
- With respect to recruitment, respondents indicate that the public child mental health system is *most likely to draw staff from: higher education graduating students; adult mental health system; other public child-serving systems, such as child welfare.* Staff for the public system are *least likely to come from the for-profit sector, higher education faculty, and parents.*
- *73% rank child psychiatrists as the most difficult discipline to recruit.*
- *In-home services were cited most frequently as the community-based service where states have the most difficulty recruiting*

staff. Clinic outpatient services were most frequently cited as the component where states have the least difficulty recruiting staff.

- Most frequently cited reasons as to why staff leave public systems are: *better salaries; more manageable caseloads; frustration with the bureaucracy; and, staff feelings of ineffectiveness with clients because of lack of access to resources.*
- *53% of respondents say staff go to the private for-profit sector, such as a for-profit hospital, or into private practice when they leave public systems.* (The private, for-profit sector, however, is not identified as a place *from* which staff come). The other most frequently cited places where staff go when they leave public child-serving systems are: *private nonprofit sector; and, other public child-serving systems*, such as child welfare.
- *There is majority consensus on the most difficult discipline to retain only with respect to child psychiatry.* This is also ranked as the most difficult to recruit.
- *In-home services are cited most frequently as the most difficult service component in which to retain staff. Clinic outpatient services are cited most frequently as the least difficult component in which to retain staff.*
- *Few retention strategies are identified* (most by local providers), and they pertain to individual local agency efforts, rather than statewide initiatives.
- With respect to understaffing concerns, respondents indicate that *the types of services where states have the most difficulty recruiting and retaining staff are: crisis services; in-home services; and therapeutic foster care.* Those surveyed indicate these are difficult components to staff and keep staffed because they tend to be characterized by high levels of *stress, irregular hours and schedules, low pay, lack of backup support, high caseloads, and inadequate training.*
- Those surveyed indicate that the service component where states have the *least difficulty recruiting and retaining staff is: clinic outpatient services.* Respondents believe it is less difficult to recruit and retain staff for this component because it *is less stressful, has regular, office-based hours and backup support, and is most like private practice.*
- Those surveyed believe it is *most difficult to recruit and retain staff for nontraditional service locations*, particularly *juvenile corrections and child protective services* settings, and least difficult to recruit and retain staff for clinic outpatient services. *Rural communities* are cited as the *most geographically understaffed* areas by all states.
- 82% of those surveyed either do not know or indicate there is *not a human resource development (HRD) office* or other capacity in their respective states *focused on the child and adolescent system*, although almost half (49%) indicate that there is an HRD office focused on the adult mental health system. 88% either do not know or indicate there is *no collaboration between the children's mental health system and their state's HRD office.* Respondents in most states cannot identify who is responsible for HRD issues related to the children's system.
- 60% of those surveyed either do not know or indicate there are *no linkages between the children's system and higher education* in their respective states to address workforce issues. *Barriers* to state-university linkages are described as *lack of time, lack of resources (staff and dollars), lack of leadership and vision on the part of both sectors, and lack of communication and understanding.*

Discussion

- There is a high level of awareness and remarkable consistency across all states and types of respondents about the directions in which states are heading. Some states are further along than others and/or are engaged on more multiple fronts, suggesting opportunity for peer-to-peer technical assistance among states in the region.
- There exists a high level of concern in every state and among every type of respondent about HRD issues, covering a wide variety of areas, including; ability to recruit appropriately trained staff; geographic distribution of staff; racial, ethnic and cultural diversity among staff; retention; in-service training; knowledge about staffing requirements; sufficient numbers of staff; and, capacity to assess, address and track HRD issues.
- The HRD issue that generates the greatest degree of consensus is ability to recruit appropriately trained staff. This concern is integrally tied to the perception that university curricula are not relevant to state priority areas, not enough of those being trained have the requisite knowledge, skills and attitudes, and not enough of those trained are entering public systems. In several states, the issue also is tied to the fact that the child mental health system must rely on staff from the adult system who do not have the necessary training in children's services.
- Although a majority are concerned, local providers do not express the same *degree of concern* over issues related to inadequate skills, inappropriate attitudes and inadequate academic preparation as do all of the other major respondent groups. Large majorities (86-100%) of state agency officials, parents and advocates, for example, express concern over states being able to access appropriately trained staff, while 56% of local providers indicate this concern. 100% of parents and state officials believe that university curricula are not relevant to state priority areas, while 56% of local providers share this view. 100% of parents and 71% of state officials believe inappropriate staff attitudes are an issue, while only 38% of local providers have this view. The other respondent groups most frequently cite staff skills and attitudes toward working with families as problem areas, but these are not concerns often cited by local providers. Additional data are needed to understand the reasons for these differences in levels of perception; one reason may be that system of care concepts that have taken several years to develop at state levels are only now beginning to move to local levels.
- Lack of in-service training seems to be related primarily to lack of funding, rather than lack of curricula. While gaps still exist in curricula in some states and some subject areas, major portions of relevant curricula do exist or are being developed.
- Responses related to recruitment and retention indicate a fair amount of staff movement among public child-serving systems, suggesting the usefulness of an interagency approach to HRD issues in the children's area.
- Responses suggest there is only one-way traffic between the public system and the for-profit sector. Staff leave public systems to enter the for-profit world, including private practice, but apparently there is little reciprocity. This raises issues for both sectors – Are public systems serving as "training grounds" for the for-profit sector with little return benefit? How can public systems become more attractive to for-profit practitioners? What is the responsibility of the for-profit sector to the public system?
- Recruitment and retention responses also suggest that public system staff rarely are drawn from the ranks of higher education

faculty, nor do public system staff tend to join faculties when they leave public service. This lack of exchange perpetuates the gap that exists between the public system and higher education.

- The absence of parents in staff roles also is cause for concern. If understanding and working with families is indeed a priority for states, involvement of parents in meaningful staff roles, much as adult systems have begun to involve consumers in staff roles, would help to foster understanding, reduce the isolation that families feel, and enhance the skills of providers and parents alike.
- Recruitment, retention and staff distribution responses all suggest a need for HRD strategies targeted to the newer types of services and to non-traditional service locations, which might include pay differentials, specialized training, smaller caseloads, more intensive on-the-job supports and backup systems, "time off" periods through rotation to other assignments, etc. There is also a need region-wide for strategies targeted to staffing rural areas and for retaining staff in inner cities.
- Responses suggest that, in most states, there is minimal systematic attention devoted to children's workforce issues, nor is there a structure at state levels to focus on this area beyond the traditional state personnel agency, which most respondents describe as marginally effective at best. The responses of parents, local providers and advocates, who left blank most questions dealing with HRD capacity, suggest that, even where states do have a focus, large groups of key stakeholders do not know about it.
- Respondents strongly believe that universities are not playing a role in encouraging persons to train in child mental health related fields, nor entering public systems if they do, nor are universities working to ensure that curricula and practica are relevant to public system needs. By the same token, respondents also believe that states are not exerting the leadership to engage and support universities to help meet public sector demands. Even steps to establish a dialogue have not occurred in most states in the region. A logical starting point for linkages is at public colleges and universities, which, according to respondents, are supplying the majority of staff to public systems and have a mission to support public concerns.

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"Unclaimed Children" Revisited: The Status of State Children's Mental Health Services

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Jane Knitzer's ***Unclaimed Children*** *(1982) described continued nationwide failure to provide services for children and adolescents with severe emotional disorders (SED). This publication marked the beginning of a movement to develop a community based system of care for children. Since 1982 there has been considerable change in the philosophy, administration and operation of services for children with SED. The current study is the first to comparatively summarize the status of children's mental health systems, state by state, since 1982. Information was obtained from written and telephone survey of State Mental Health Representatives for Children and Youth. The survey instrument was designed to mirror the questions posed by Knitzer in 1982. Surveys inquired about administrative structure and operational responsibilities, pertinent legislation, parent involvement, definitions of target populations, out of state placements, placements on adult wards, and official visions of an ideal system of care. Since the intent of the study was to catalogue, rather than critique the changes state results are presented in summary, rather than rank-ordered form. Results indicated a marked increase in the number state administrative offices and staff for child/adolescent (C/A) mental health. All states currently have at least one full time professional staff member dedicated to C/A mental health. State laws pertaining to C/A mental health have influenced many aspects of the development of the system of care. Most states had developed definitions of their target population. Many states reported high numbers of out of state placements, and often counts of these placements were not available. Placement of minors in adult psychiatric wards still occurs, and the availability of that information to C/A mental health administrators is often lacking. Lastly, states have largely embraced the CASSP principles as their ideal vision of a system of care.*

Introduction

In *Unclaimed Children* (1982) Jane Knitzer published the results of a national study of mental health services for children with Severe Emotional Disturbance (SED). Through survey of state leaders in children's mental health, and review of Federal and state statutes pertaining to children's mental health services, she found large gaps in service options, and on-going failure of systems to meet the needs of children. with SED She estimated that two-thirds of these children did not receive needed services. *Unclaimed Children* marked the beginning of a movement to develop a community based system of care for children (Stroul & Friedman, 1986).

Since 1982 there has been considerable positive change in the philosophy, administration and operation of services for children with serious emotional disturbance. In 1984, Congress funded an initiative to demonstrate the development of better functioning service systems, which resulted in the National Institute of Mental Health developing the Child and Family Adolescent Service System Program (CASSP). CASSP supports state development of interagency efforts to improve the systems of care in which the most troubled children and youth receive services. As of 1992 every state had received at least one CASSP grant (for 3-5 years), and all states have developed a vision of a system of care that guides their system development. Additionally, several private foundations have focused initiatives on troubled children and youth. For example, the Robert Wood Johnson Foundation funded pilot sites in 10 states, the Edna McConnel Clark Foundation has supported the development of family preservation services in all states, and the Annie E. Casey Foundation has recently launched an initiative for interagency collaboration to help urban youth in 6 sites. Each of these initiatives emphasizes development of a system of care and services for troubled or disturbed youth. Additionally, forums for discussing the results of these and other initiatives have become more common, and 'systems of care' has become a common phrase among policy makers, administrators and providers of services for children with SED. Lastly, PL 99-660 mandated the establishment of a comprehensive, community-based system of care for seriously mentally ill adults and children in every state.

Many of these initiatives emphasize the need to evaluate the developing system of care, and many sites have done so. However, no published study has comprehensively examined the results of this decade of change. The aim of the current study was to examine the status of state child/adolescent (C/A) mental health systems in all 50 states and the District of Columbia, and provide summary information about the changes that have occurred since Knitzer's seminal study in 1982. This study was not designed to rank or critique state systems, rather it was designed to catalogue the changes.

Methods

Information filed with the CASSP Administrative Office at the Center for Mental Health Services in the Substance Abuse and Mental Health Services Administration, including State Mental Health Plans, were examined to see what aspects of the system of care states had chosen to develop, and in what ways states varied in their approach to developing a system. These categories were combined with similar questions, or natural follow-up questions to Knitzer's (1982) survey, to develop the current survey. Additionally, the information gleaned from the documents at the CASSP Office was used to fill out each state's survey as much as possible. These partially completed surveys were then mailed to State Mental Health Representatives for Children and Youth (SMHRCY), in each state and the District of Columbia, with a request that they change any incorrect information we had obtained, and to fill in the questions for which we did not have information. The questions covered the areas of:

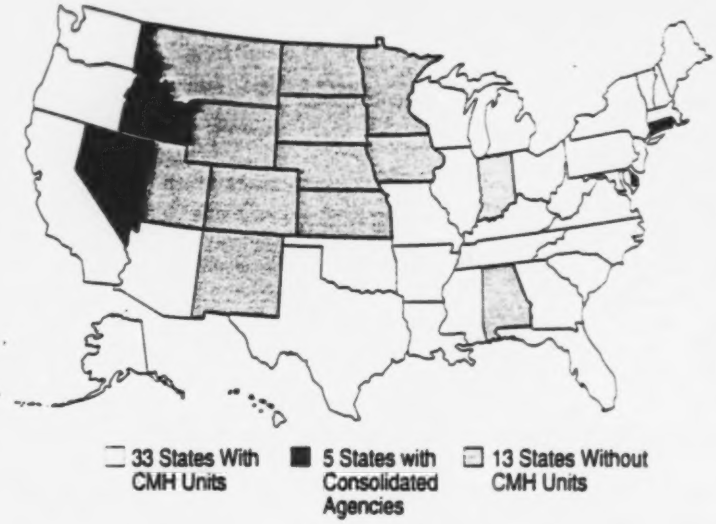
1. Organization and responsibilities of state level children's mental health administration;
2. The presence or absence of a separate children's mental health budget,
3. Pertinent legislation,
4. Definition of the target population for development of a system of care,
5. The presence of parent/family advocacy and support organizations,
6. State visions of the system of care, and
7. Numbers of out-of-state placements and placements of minors on adult psychiatric wards during the past year.

Completed surveys were obtained in one of three ways: mailing, faxing or phone interviewing. Phone interviews were conducted by the first author ($N = 21$). All surveys were completed between 2/3/93 and 3/3/93. Data presented in this paper include the responses from 48 states and the District of Columbia. Descriptive statistics were used to summarize the findings. The current data were compared to that presented in *Unclaimed Children* and a 1988-89 unpublished survey conducted by Ira Lourie and Miriam Bernstein.

Results

One of the cornerstones of Knitzer's study was to establish how many states had instituted an administrative organizational entity, or unit, to take lead responsibility for children's mental health service matters. In 1982 Knitzer, reporting on 50 states, found that only 21 had C/A mental health units. At that time 2 of the 29 states that did not have identifiable C/A mental health unit, had had one previously and lost it. One of these states had lost their separate C/A mental health division in converting to a consolidated C/A agency. This was the only state that had a consolidated C/A agency at the time. For the present survey administrative units were defined as organized administrative entities that contain at least 2 FTE positions. Two FTE positions were chosen as a criterion because of the limitations of the operational and administrative responsibilities that one person can accomplish. Present results indicated that, as of February, 1993, there were 33 states with separate C/A mental health units located within the state's mental health agency (see Figure 1). Additionally, 5 states had a consolidated children's agency that includes C/A mental health. C/A mental health had a separate administrative unit within 4 of these 5 consolidated agencies. Thirteen states had no separate unit for C/A mental health. Eleven of these 13 states constituted a block of states in the midwest ranging from Montana to Minnesota along the northern border to New Mexico along the southern border. Alabama and Indiana are the other two states without C/A mental health Units.[1] It is likely that the absence of identifiable units in these states is related to their shared characteristic as large, mostly rural states with low population densities and largely decentralized state agencies in general.

Figure 1
Map of States Categorized by Organization of Children's Mental Health Administrative Staff at the State Level


☐ 33 States With CMH Units
■ 5 States with Consolidated Agencies
▨ 13 States Without CMH Units

The current data were combined with that collected by Lourie and Bernstein (unpublished) to examine the cumulative growth of identifiable state C/A mental health units, or consolidated agencies, for the 35 states for which we have dates of origin (see Figure 2). The first C/A

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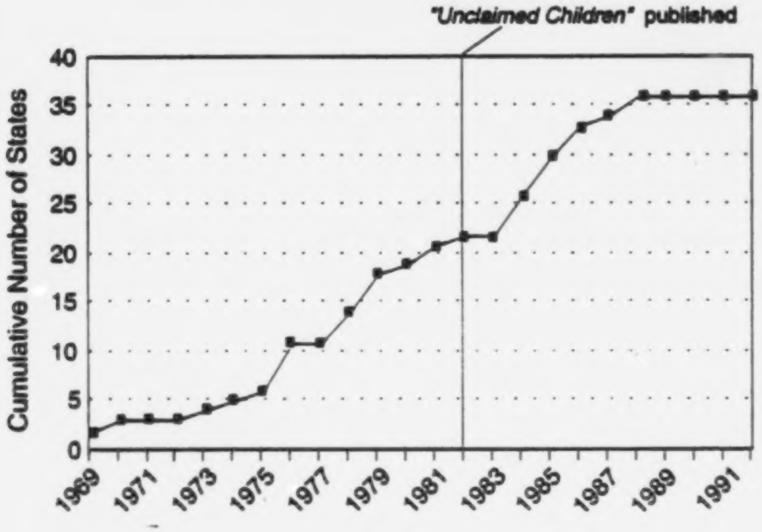
[1] Several states reported that they had C/A mental health units, however the number of FTE's in that unit was less than 2. We have included them in the category of not having a functional C/A mental health unit because of the limitations of the operational responsibilities that one person can accomplish. The following states fall into this category: IN, KS, ND.

Figure 2
Growth of the Number of States with Identifiable State Level Children's Mental Health Service Units



mental health unit (North Carolina) was established in 1969. There was a steady increase in the number of states with C/A mental health units from 1975 to 1988 (growing from 5 to 35 Units). There has been no new C/A mental health unit formed since 1988[2].

Currently, every state has at least one full time equivalent position dedicated to C/A mental health, and every state has a SMHRCY person. Overall examination of the number of full-time equivalent positions dedicated to C/A mental health administration at the state level revealed a significant difference between those states with an identifiable unit and those without. States with an identifiable unit had 2 to 16 FTE's (see Figure 3). Those without a unit had 1 to 3.6 FTE's. This was a statistically significant difference (Mann-Whitney $U = 18.5$, $Z = -4.4$, $p < .0001$, see Figure 3).

Another area of major change was in state budgets for C/A mental health services. In 1981, of the 33 states for whom budgetary information was obtained, only 18% had a separate state budget for C/A mental health. In 1993 that number had grown to 70% (of 49 states) with a C/A mental health state budget. Many C/A mental health units (87%) had the responsibility of developing and administering those dollars, and/or other dollars. Forty-six to fifty-five percent (respectively) of states without units reported that C/A mental health staff developed and administered budgets. Examination of other administrative responsibilities carried out by C/A mental health unit staff and C/A mental health staff from states without a C/A mental health unit revealed that all units had the responsibility of program planning and policy development, > 85% had the responsibility of monitoring/regulating programs, and most (72-75%) initiated legislation and did training. The staff from 93% of states without C/A mental health units had responsibility for program planning, most (74-83%) monitored or regulated programs, did training and developed policy. Staff from 55% of states without units initiated legislation. Only 30% of C/A mental health units had direct line responsibilities for direct services and none of the staff from states without units had this responsibility. Overall, counting the number of different responsibilities (out of a total of 8 possible) carried out by C/A administrative staff, staff organized into units had more responsibilities than did staff not organized into units (Mean Units = 6.5 ± 1.2, not Units = 4.9 ± 2.1, $t(df = 16.54) = 2.67$, $p < .02$).

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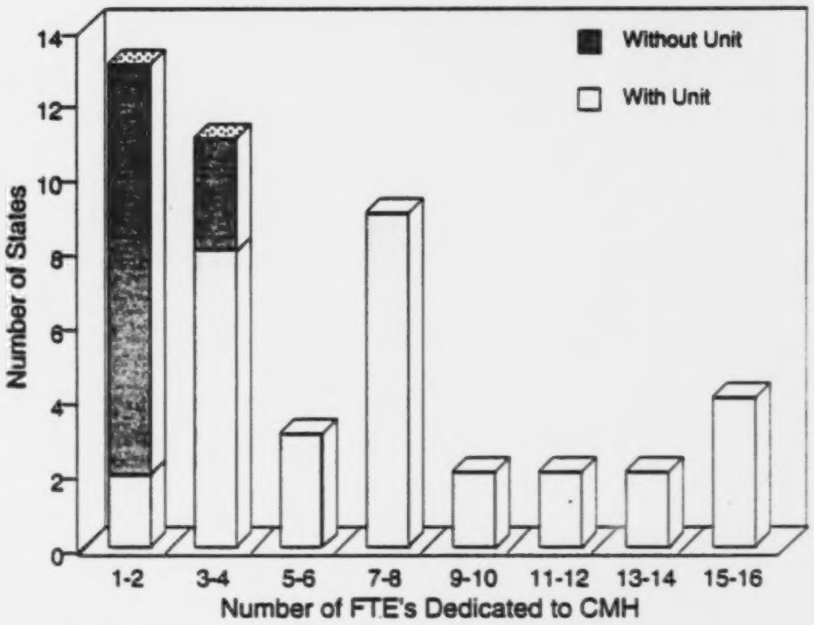
[2] Indiana passed legislation to form a C/A mental health unit in July 1992, however only one FTE position had been funded for C/A mental health as of 2/93.

Figure 3
Distribution of Total FTE Positions Dedicated to Children's Mental Health Services at the State Level



There has been a considerable evolution in laws that are pertinent to the system of care. The most prevalent state laws concerning C/A mental health were those that created state level interagency councils for planning, and state or local level interagency case review board or treatment planning processes (see Figure 4). Twenty-five states had defined their system of care for youth by law. Numerous states had mandated specific C/A mental health projects (such as a pilot project of pooled funding in 4 counties in one state), had required specific clinical services, or had broadened their medicaid options regarding children's mental health services. Twenty-two states mandated parental involvement in policy making, program planning or treatment planning (see Figure 4). It should be noted that every state reported at least one parent-lead advocacy group that focused on children's mental health issues, and offered support groups to family members of children with SED.

All but one state had defined a target population for development of a system of care. These definitions were found either in law or policy. State approaches to defining the target population was markedly varied, but generally included elements of diagnosis, duration of condition, multi-agency involvement, out-of-home placement and functional disability. The one point of consensus was that 92% of reporting states included consideration of a functional disability. Of the 45 states that included functional disability resulting from mental illness in the target population definition 17% used a functional disability scale score cutoff to determine functional impairment (ie., C-GAS score $\leq$ 50). The remaining states generally identify functional disabilities in four domains: family relations, social behavior, learning/ school and self care. Of the 31 states that included some discussion of DSMIII-R diagnoses as part of their definition of a target population, 23 had specific exclusionary primary diagnoses, while 8 do not. Exclusions included primary diagnosis of V-Codes, Substance Abuse, Mental Retardation, Autism and Organic Brain Syndrome.

Many states still have children traveling out of state for residential care. However, exact numbers were not possible since many states did not have figures available. Twenty percent

Figure 4
Number of States Passing Types of Laws That Have an Impact on Developing Systems of Care

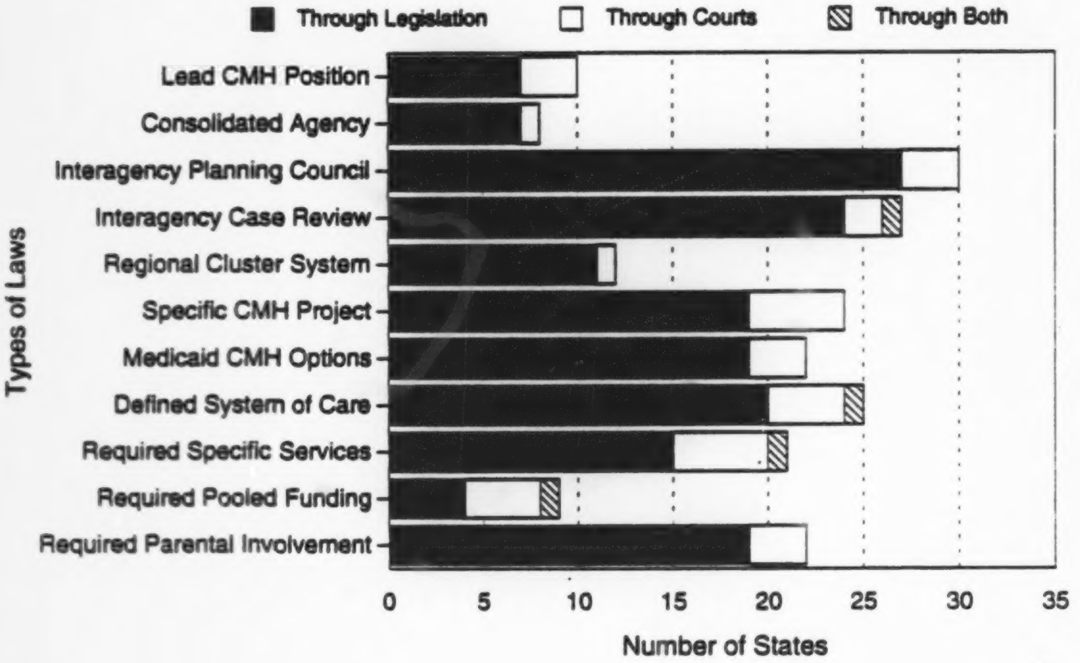


Table 1
Number of Out of State Placements for FY '92 or Calendar Year '92

	Mental Health	Child Welfare	Juvenile Justice	Education	Total
Mean ± S. D.:	5.3 ± 15.5 (*n* = 39)	76.2 ± 93.8 (*n* = 25)	8.6 ± 21.6 (*n* = 17)	31.2 ± 78.9 (*n* = 21)	186.2 ± 271.1 (*n* = 20)
% of States with No placements	53%	4%	22%	16%	0%
% of States with No Count Available	20%	49%	65%	57%	59%

of states reported the figures for out-of-state placement through mental health were unavailable (see Table 1). Even fewer states had figures available from other agencies. It is likely that the missing information would indicate some placements through these agencies. The greatest number of children were placed through child welfare. The fewest number of children appeared to be placed through mental health (Mean = 5.33 ± 15.5 *S.D.*, *n* = 39), with 53% of states placing no children through this agency. No states reported no out of state placements (although Alaska had only 1 as of 3/3/93). While the average number of total out of state placements for those states reporting (*N* = 20) is quite high (Mean = 186.2 ± 271.1 *S.D.*), most of these states had counts under 100 (13 states). The remaining 7 states had very high numbers ranging from 189 to 1100.

Similarly, 41% of states reported that information on the number of children, for whom the state had responsibility, that were treated in adult psychiatric wards during the past year (fiscal or calendar) was unavailable. The figures on minors receiving services on adult psychiatric wards refer only to public facilities, or facilities in which the state could place individuals, and does not reflect private hospital practices. Twenty states reported that no minors were treated on adult psychiatric units. Many of these states had laws prohibiting such placements. Six states reported that there was at least one minor treated on adult wards (range 1-73).

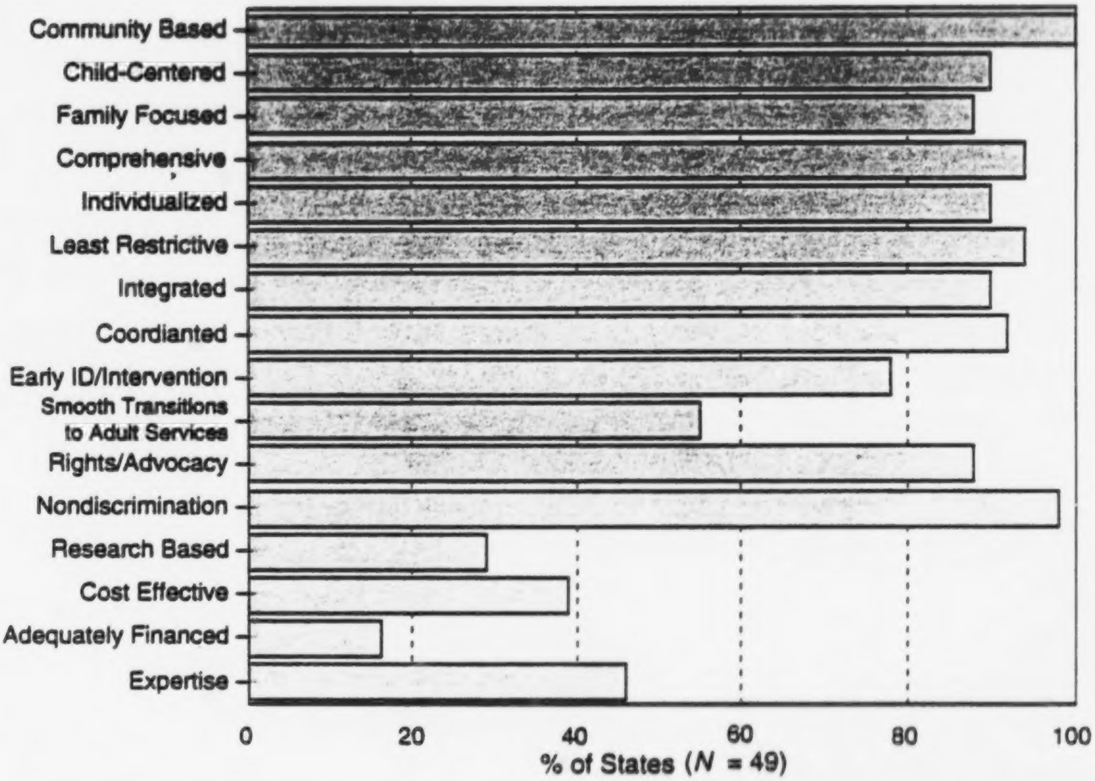
Lastly, examination of the official vision of a system of care for children with emotional disturbance (by law or policy) revealed that all states promote community based services. The vast majority of the remaining elements set forth by CASSP as forming an ideal system of care were embraced by 89-98% of reporting states (see Figure 5). Fewer states embraced the element of early identification and intervention. The least frequently cited element of the CASSP model of a system of care, included by only 55% of states, was that of smooth transition to adult services. States were also beginning to add other categories to the vision including specific expertise in children's mental health, services that were cost effective, and services that are adequately financed. Lastly, 29% of states reported that their ideal vision of a system of care would be guided by a research base.

Conclusions

It is clear from these data that significant progress has been made in the structure and elements that support the expansion of the system of care for youth with SED. Many more states have organized their C/A mental health staff into formal offices, and have increased the number of positions dedicated to C/A mental health. The presence of separate administrative units has many ramifications for the development and maintenance of states' systems of care for youth. One important aspect is that it demonstrates official recognition of separate needs of C/A and adult mental health. It also provides a forum in which professionals, who have specialized training and experience in C/A mental health issues, take a leadership role in guiding the development and ongoing management of the system of care for youth. These professionals can also serve as C/A mental health advocates from within the state mental health system.

Another consequence of organizing C/A staff into units is that more administrative responsibilities can be taken on by C/A staff. This is supported by the current data. Specifically, for each administrative responsibility, proportionately more states with separate units fulfilled that responsibility with C/A staff than states without units. Additionally, staff organized into units covered more kinds of responsibilities than staff not organized into units. This suggests that in states without separate units, more responsibilities for C/A services are handled by non C/A staff. Thus, the increase in C/A units is related to the general increase in the number of responsibilities assumed by C/A mental health staff. Another correlate of the increase

Figure 5
Percent of States Officially Embracing Various CASSP Principles in Their Vision of an Ideal System of Care [a]



[a] Four additional categories were added because a significant number of states included them in their official vision; the system should be research based, cost effective, and adequately financed and professionals should have specific expertise in the area of children's mental health.

in separate units is the increase in the number of FTE's dedicated to C/A mental health, and the number of states that have specific state budgets for C/A mental health. Taken together, these data indicate that there has been tremendous operational growth in C/A mental health services, with increased numbers of administrative units, staff, responsibilities and separate budgets.

Laws have been passed that have promoted positive change in the system of care. There is now a much more common vocabulary to discuss the population with SED in terms of who they are, and what qualifies children as having SED. Formalization of definitions of target populations will help promote needed research in this area. There was also a much larger network of family advocacy groups that focus mainly on mental health issues of children and their families.

However, there is much work to be done in the realm of most disruptive placements. There are still many children who are going out of state for residential treatment, and children are still being treated on adult psychiatric wards. Just as important is the fact that the lead person for children's mental health in many of these states did not have these figures available to them. Hence, while there is much to feel positive about there remains much to do. It is heartening to see that a vision of an ideal system of care has been officially articulated for every state, and that movement towards those visions will do much to address the many problems remaining in the way children and their families are served.

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Does Program Auspice Impact on the Delivery of Services to Children with Emotional Disturbance? A Study of Residential Treatment Programs (and Their Delivery Systems) in Florida

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While there is some empirical evidence which suggests differences between the relative effectiveness of non-profit and for-profit adult care providers, little research has been conducted concerning the impact of auspice (legal status of a program incorporated as a public, private, private non-profit, or private for-profit program) *on either (a) child care provider effectiveness, or (b) the ability of delivery systems to provide services to children with emotional disturbances. This study investigates the impact of program auspice on the ability of all of the programs in a delivery system to provide services to children with emotional disturbance who have been placed in residential treatment centers (RTCs). Using a focal organization approach, a sample consisting of eighteen RTCs (and their associated delivery systems) located within the state of Florida that primarily served children with emotional disturbance, was derived. Data were obtained from mail/telephone survey questionnaires and public/private organization documents. Study results supported the associations between public or private delivery system program auspice and the availability of adjunctive, behavioral evaluation, educational evaluation, medical evaluation, and placement/post placement/day services.*

Introduction

Prior to the 1960s, human service programs, including programs for children with emotional disturbance, were operated almost exclusively by public and private non-profit organizations. Questions regarding the auspice (legal status of a program incorporated as a public, private, private non-profit, or private for-profit program) of these programs were concerned with the relationships between public and private non-profit providers (Kramer, 1979 and Kahn, 1976). With the increasing involvement, after the mid-1970s, of commercial for-profit agencies in the management of human service programs, new questions emerged as to whether public and both private non-profit and for-profit programs could meet the needs of clients from diverse backgrounds. For example, Shore (1992) editorialized in the July, 1992 issue of the American Journal of Orthopsychiatry about the privatization of the public sector, the demise of non-profit programs, and the tendency of for-profit providers to "cream off" paying clients. He questioned, given these problems, whether middle-class Americans with inadequate health coverage could obtain high quality mental health services in the decade of the 1990s. While there is some empirical evidence that suggests differences between the relative effectiveness of non- profit and for-profit adult care providers (Kiesler, 1982; Pattison & Katz, 1983; and Kaye, Monk, & Litwin, 1984), little research has been conducted concerning the impact of auspice on either child care provider effectiveness, or the ability of delivery systems to provide services to children, including children with emotional disturbance.

The exploratory study described in this paper investigated the impact of program auspice on the capacity (or ability) of all of the programs within a delivery system to provide services to children with emotional disturbance who had been placed in residential treatment centers (RTCs). Delivery systems were viewed as the network of organizations (e.g., juvenile courts, schools, hospitals, clinics, and day care centers) that interacted with a RTC to provide services to the RTC children. Children with emotional disturbance were regarded as minors below the age of nineteen who had been diagnosed as having a mental disorder as defined in the Diagnostic and Statistical Manual (Third edition-revised) of the American Psychiatric Association (1987). Residential treatment centers were viewed as programs that provided 24-hour care and treatment services seven days a week to nine or more children, many of whom were emotionally disturbed. The study investigated two research questions pertaining to the ability of delivery systems to provide services to children with emotional disturbance.

1. What is the relationship between the auspice of the delivery system RTC program and the auspice of the other delivery system programs?
2. What is the relationship between the auspice of the delivery system programs and the capacity of the delivery system to provide services to children with emotional disturbance in residential treatment programs?

Method

Sampling Plan and Procedure

Using a focal organization[1] approach, a sampling frame list that consisted of thirty-one RTCs (and their associated delivery systems) located within the state of Florida was derived from a review of the RTC programs described in five documents. The documents included:

1. The Florida Department of Health and Rehabilitative Services (HRS) Children, Youth, and Families (CYF) Program Office roster of licensed child caring and child placing programs;
2. The HRS Child Mental Health Program Office roster of residential child caring programs;
3. The National Directory of Children and Youth Services (1990-1991);
4. The Florida HRS Mental Health Program Office Directory of State Supported Alcohol, Drug Abuse, and Mental Health Community Services; and
5. The American Hospital Association Guide to the Health Care Field (1989).

Residential treatment programs, which were viewed as the focal points of their delivery systems, were included in the sampling frame list if they (a) were licensed as child caring agencies and/or as hospitals, (b) served nine or more children, and/or (c) were programmatically oriented toward the care and treatment of children with emotional disturbance (as opposed to children with developmental disabilities, mental retardation, or substance abuse disorder). Data for the study were obtained between September and November of 1990, according to the following procedure:

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[1] According to the focal organization approach developed by Evan (1966), organizational relationships with environmental entities, especially organizational entities, can be studied through the organizational-set concept. This involves analyzing the relationships between an organizational-set reference or focal organization and the network of other organizations in the set or delivery system as a series of exchanges from the standpoint of the focal organization

1. Survey questionnaires were sent to the executive directors of the thirty-one RTC programs included on the sampling frame list in order to obtain information regarding: (a) the characteristics including the auspice, of each of the RTCs; (b) the names, addresses, and telephone numbers of each of the programs that provided services to children with emotional disturbance placed in each of the RTCs; and (c) the services provided by each of the delivery system programs, including the residential treatment programs. Follow-up telephone calls were made to the executive directors/staff who did not return their questionnaires in a timely manner in order to try to obtain closure from them regarding their willingness to participate in the study. Calls were also made to those who had returned questionnaires that contained missing information in order to obtain more complete data. Out of the thirty-one questionnaires sent to the RTC program executive directors, eighteen questionnaires were returned and were usable, representing a response rate of 59 % (of the 13 questionnaires that were not returned or usable, 10 questionnaires were not returned, and 3 questionnaires were returned but contained incomplete information).
2. Auspice data as well as selected demographic data on each of the delivery system programs that provided services to children with emotional disturbance placed into the RTC programs were obtained from a number of sources. These included American Hospital Association publications, Florida Education and Health and Rehabilitative Services Department publications, Florida Department of State Corporate Office Computer Database information, and selected agency staff telephone contacts.

The Study Variables

Service capacity variable.

Service capacity was operationalized as the number (or proportion) of services that were available to the children (out of the total number of services that ideally should be available to them). In order to measure service capacity, a list of 86 services (see Appendix A) that, according to the literature, should be provided to children with emotional disturbance was developed and incorporated into the survey questionnaire. The list was derived from a content review of manuals/books pertaining to (a) the accreditation of child care/treatment programs and the child mental health field, and (b) recommendations made by child welfare/mental health professionals who participated in a pretest of the survey questionnaire. The manuals/books were published by the Child Welfare League of America, the Joint Commission on the Accreditation of Healthcare Organizations, and the Joint Commission on the Mental Health of Children. Each of the RTC executive directors (and/or their staff) were asked to indicate which of the services on the list were available to the children with emotional disturbance who were supervised by their programs.

Program auspice variable.

Program auspice was operationalized as the legal status of a program, that is, whether the program was legally incorporated as a public, private, private non-profit, or private for-profit program.

Data Analysis

A variety of descriptive statistics (i.e., minimum and maximum values, measures of central tendency, and standard deviations) were employed to describe selected RTC program/delivery system characteristics. Contingency coefficients were used to assess the first research question relationships and the Spearman rank order statistic was used to assess the second research question relationships. A correctional technique was applied to the Spearman rank order calculations if too many within rank ties occurred (Blalock, 1972). Finally, all second research question correlations were regarded as significant if they achieved at least the .05 level of significance.

Results: Description of the Sample

Residential Treatment Programs

The data concerning RTC program location, subsidiary status, auspice, age, size, and client length of stay characteristics are depicted in Tables 1 and 2. The largest proportion of RTC programs were located in North Florida (39%), followed by Central Florida (33%), and South Florida (28%). Most of the programs were non-free standing (72%) as opposed to free standing (28%)[2]. All of the programs were operated as private auspice programs. The RTC programs were fairly small (their caseload and staff sizes averaged twenty-five children and forty employees respectively). The ages of the programs averaged fourteen years and all of the programs provided long-term services with the average length of stay at 360 days.

Table 1
Residential Treatment Program Location, Subsidiary Status, and Auspice Characteristics

Characteristics	Percentage	Number
Program Location		
North Florida	0.39	*N* = 7
Central Florida	0.33	*N* = 6
South Florida	0.28	*N* = 5
	1.00	*N* = 18
Program Subsidiary Status		
Free Standing	0.28	*N* = 5
Non-Free Standing	0.72	*N* = 13
	1.00	*N* = 18
Program Auspice		
Public	.00	*N* = 0
Private	1.00	*N* = 18
	1.00	*N* = 18
Non-Profit	0.61	*N* = 11
For-Profit	0.39	*N* = 7
	1.00	*N* = 18

All Delivery System Programs

The data concerning delivery system size and delivery system program subsidiary status characteristics are depicted in Tables 3 and 4. Delivery system size (defined as the total number of programs in each delivery system) ranged from four to nineteen programs and averaged 8.6 programs per system. Health programs accounted for the largest type of delivery system program across all systems with a mean of 3.2 programs per system, closely followed by mental health and education programs with means of 2.4 and 2.3 programs per system, respectively. Both child welfare and legal programs were extremely under-represented in the sample.

Table 2
Residential Treatment Program Age, Size, and Client Length of Stay Characteristics

Characteristic	Mean	Median	Min	Max	*SD*
Program Age (a)	169	106	17	1178	260.03
Program Size					
Caseload Size	25	18	8	68	17.84
Staff Size	40	23	8	120	31.55
Program Client Length of Stay (b)	360	365	97	730	176.13

N = 18 programs.
(a) Program age is expressed in months.
(b) Length of stay is expressed in days.

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[2] A non-freestanding program is part of a larger program or organization. For example, a school in a school district is a part of the school district. A freestanding program is not part of a larger program or organization and stands by itself.

Child welfare programs ranged from zero to six programs per delivery system with an average of 0.61 programs, while legal programs ranged from zero to two programs per delivery system with an average of 0.01 programs. The proportion of non-free standing programs in all of the delivery systems clearly exceeded the proportion of free-standing programs (system means of 62% and 38% respectively). Education programs accounted for the largest proportion of non-free standing programs with a system mean of 88%, followed by mental health programs with a system mean of 64%. Health programs accounted for the largest proportion of free-standing programs with a system mean of 64%, followed by mental health programs with a system mean of 37%.

Table 3
Delivery System Size

	Number of Programs					
Delivery System Programs	Mean	Median	Mode	Min	Max	*SD*
All Programs	8.60	7.50	9.00	4.0	19.0	4.300
Education Programs	2.30	1.00	1.00	0.0	7.0	1.994
Health Programs	3.20	3.00	2.00	1.0	6.0	1.664
Mental Health Programs	2.40	2.00	2.00	1.0	5.0	1.419
Child Welfare Programs (a)	.61	0.00	0.00	0.0	6.0	NA
Legal Programs (b)	.01	0.00	0.00	0.0	2.0	NA

N = **18 delivery systems.**
(a) Based on four delivery systems.
(b) Based on one delivery system.

Table 4
Delivery System Program Subsidiary Status

	Proportions of Free Standing and Non-Free Standing Programs			
Delivery System Programs	Mean	Min	Max	*SD*
Free Standing Programs				
All Programs	.38	.11	0.71	.190
Education Programs	.02	.00	0.25	.066
Health Programs	.64	.00	1.00	.286
Mental Health Programs	.37	.00	1.00	.344
Child Welfare Programs	.00	.00	0.00	.000
Legal Programs	.00	.00	0.00	.000
Non-Free Standing Programs				
All Programs	.62	.29	0.89	.190
Education Programs	.88	.00	1.00	.322
Health Programs	.40	.00	1.00	.323
Mental Health Programs	.64	.00	1.00	.329
Child Welfare Programs (a)	.22	.00	1.00	.428
Legal Programs (b)	.06	.00	1.00	.236

N = **18 delivery systems.**
(a) Based on four delivery systems.
(b) Based on one delivery system.

Program Auspice Variable

Table 5 depicts the auspice of the delivery system programs. The majority of delivery system programs were private auspice programs. While the proportions of public auspice programs in each system ranged from zero percent (indicating no programs) to 75% with a mean of 41%, the proportions of private auspice programs in each system ranged from 25 to 100% with a mean of 59%. Education programs accounted for the largest proportion of public auspice programs across all of the delivery systems. They ranged from zero percent (indicating no programs) to 100% per system

Table 5
Proportions of Public and Private Auspice Delivery System Programs

Delivery System Programs	Mean	Min	Max	*SD*
Public Auspice Programs				
All Programs	.41	.00	.75	.244
Education Programs	.87	.00	1.00	.322
Health Programs	.13	.00	.50	.211
Mental Health Programs	.19	.00	.50	.242
Child Welfare Programs (a)	.22	.00	1.00	.428
Legal Programs (b)	.06	.00	1.00	—
Private Auspice Programs				
All Programs	.59	.25	1.00	.244
Education Programs	.02	.00	.25	.066
Health Programs	.87	.50	1.00	.211
Mental Health Programs	.82	.50	1.00	.242
Child Welfare Programs (a)	.00	.00	.00	—
Legal Programs (b)	.00	.00	.00	—
Private Not-for-Profit Programs				
All Programs	.50	.00	1.00	.295
Education Programs	.11	.00	1.00	.323
Health Programs	.39	.00	1.00	.369
Mental Health Programs	.63	.00	1.00	.442
Child Welfare Programs (a)	.00	.00	.00	—
Legal Programs (b)	.00	.00	.00	—
Private For-Profit Programs				
All Programs	.50	.00	1.00	.289
Education Programs	.00	.00	.00	—
Health Programs	.60	.00	.00	.363
Mental Health Programs	.37	.00	1.00	.442
Child Welfare Programs (a)	.00	.00	.00	—
Legal Programs (b)	.00	.00	.00	—

N = 18 delivery systems.
(a) Based on four delivery systems.
(b) Based on one delivery system.

with a mean of 87%. The private auspice programs were evenly represented by non-profit and for-profit programs with means of 50% for each auspice type across systems. Health and mental health programs comprised the largest proportions of private auspice delivery system programs with system means of 87% and 82% respectively. While health programs accounted for a clear majority of the for-profit programs with a system mean of 60%, mental health programs comprised a clear majority of the non-profit programs with a system mean of 63%.

Service Availability Variable

Table 6 describes the availability of the delivery system services. The proportions of total available services varied somewhat across the delivery systems, ranging from 31 to 90% per system with a system mean of 68%. Several specialized evaluations (educational, behavioral, and medical) were clustered together and accounted for the largest proportions of available services with system means of 87%, 86%, and 85% respectively. Recreational services comprised the next largest category of services (77%), closely followed by general evaluations, behavioral treatment services, education services, and medical services (with system means of 75%, 74%, 69%, and 67% respectively).

Study Relationships

First Research Question:

What is the relationship between the auspice of the delivery system RTC program and the auspice of the other delivery system programs?

The data in Table 7 describe the relationships between the auspice of the delivery system RTC program and the auspice of the other delivery system programs. The information is sum-marized below:

1. There was a weak association between the number of private non-profit and for-profit auspice RTC programs and (a) the number of

public, private non-profit, and private for-profit non-RTC delivery system programs ($C = .25$); (b) the number of public and private non-RTC delivery system programs ($C = .21$); (c) the number of public, private non-profit, and private for-profit delivery system medical programs ($C = .21$); and (d) the number of public and private delivery system mental health programs ($C = .27$).

2. There was a moderate association between the number of private non-profit and for-profit RTC programs and the number of public, private non-profit, and private for-profit delivery system mental health programs ($C = .40$).

Table 6
Delivery System Service Availability Variable

Service Categories	Proportions of Available Services Mean	Min	Max	*SD*
Total Available Services	.68	.31	0.90	.146
General Evaluations	.75	.38	1.00	.177
Behavioral Evaluations	.86	.20	1.00	.245
Medical Evaluations	.85	.40	1.00	.182
Education Evaluations	.87	.00	1.00	.298
Placement/Post Placement/Day Services	.54	.11	1.00	.295
Behavioral Treatment Services	.74	.46	1.00	.170
Medical Treatment Services	.67	.17	0.83	.221
Education Services	.69	.00	1.00	.314
Recreation Services	.77	.44	1.00	.224
Adjunctive Services	.29	.00	0.92	.241

$N = 18$ delivery systems.

Second Research Question:

What is the relationship between the auspice of the delivery system programs and the capacity of the delivery system to provide services to children with emotional disturbance?

The data in Tables 8, 9, and 10 describe the relationships between delivery system program auspice and the availability of delivery system services. Following is a summary of the data:

1. There was a negative association between the proportion of public auspice delivery system programs and the availability of delivery system medical evaluation services (-.4796, $p < .045$), and a positive association between the proportion of public auspice delivery system programs and the availability of delivery system adjunctive services (.5533, $p < .018$).
2. There was (a) a strong positive association between the proportion of public auspice child welfare delivery system programs and the availability of delivery system adjunctive services (.7046, $p < .002$), and (b) a positive association between the proportion of public auspice child welfare delivery system programs and the availability of general evaluation services (.4669, $p < .051$).
3. There was a positive association between the proportion of private auspice delivery system programs and the availability of delivery system medical evaluation services (.4718, $p < .045$).
4. There was a negative association between the proportion of private auspice delivery system programs and the availability of delivery system adjunctive services (- .5639, $p < .015$).
5. There was a positive association between the proportion of private non-profit auspice delivery system programs and the availability of placement/post placement/day services (.5586, $p < .016$). Conversely, there was a negative association between the proportion of private for-profit auspice programs and the availability of placement/post placement/day services (-.5167, $p < .029$).

6. There was a positive association between the proportions of private non-profit auspice delivery system health programs and the availability of (a) delivery system medical evaluation services (.5354, $p < .023$), (b) delivery system education evaluation services (.5150, $p < .029$), and (c) delivery system placement/post-placement/day services (.5880, $p < .011$). Conversely, there was a negative association between the proportion of private for-profit auspice delivery system health programs and the availability of the same delivery system services (-.5279, $p < .025$; -.4981, $p < .036$; and -.5583, $p < .017$ respectively).
7. There was a negative association between (a) the proportion of private non-profit mental health programs and the availability of delivery system behavior evaluation services (-.4968, $p < .036$), and (b) the proportion of private for-profit auspice delivery system mental health programs and the availability of delivery system placement/post placement/day services (-.5327, $p < .023$).

Discussion of Results

Due to the methodological problems associated with the small number of delivery systems that contained child welfare programs ($n = 4$), the study results concerning the relationships between public child welfare delivery system program auspice and the availability of delivery system general evaluation and adjunctive services should be viewed with caution. However, the other study auspice variable relationship results might be interpreted according to the rationale that organizational programs possess characteristics (e.g., age and auspice) that can influence (a) the manner in which other programs, individuals, and groups perceive the programs and interact with them, and (b) the manner in which services are provided by the delivery system programs (Perrow, 1979). As such, one might argue that the link between delivery system program auspice and the availability of delivery system program services is a matter of program self-perceptions that are shaped by other delivery

Table 7

RTC and Non-RTC Delivery System Program Auspice Relationships

RTC Program Relationships with:	Contingency Coefficient
All public and all private non-profit and for-profit delivery system programs	.25
All public and all private delivery system programs	.21
All public and all private non-profit and for-profit delivery system medical programs	.21
All public and all private delivery system medical programs	.01
All public and all private non-profit and for-profit delivery system mental health programs	.40
All public and all private delivery system mental health programs	.27

Note: Contingency coefficients pertaining to the relationships between RTC program auspice and delivery system child welfare, education, and legal program auspice were not computed because only one private education program was included in the sample, and no private child welfare or legal programs were included in the sample.

system program perceptions. One might speculate that:

1. Delivery systems with larger proportions of either public programs or private non-profit health programs, that by virtue of social stereotype are viewed (and view themselves) as non-technology and service (rather than profit) oriented, tend to work with similar philosophy programs, and as a delivery system are more likely to provide services (e.g., adjunctive, behavioral evaluation, educational evaluation, placement/post placement/day, and medical services) that are reimbursed either at cost or below cost.
2. Delivery systems with larger proportions of private programs that are technology and profit oriented tend to positively impact on the ability of their delivery systems to provide medical evaluation services that are often reimbursed above cost: and (b) delivery systems with larger proportions of private programs, including private for-profit health and mental health programs, that are technology and profit (rather than service) oriented, tend to negatively impact on the ability of their delivery systems to provide adjunctive, behavioral evaluation, educational evaluation, and placement/

Table 8
Relationships Between Delivery System Public Program Auspice and the Availability of Delivery System Services

	Proportions of Available Services										
Delivery System Public Program Auspice	Total Services	General Evaluations	Behavioral Evaluations	Medical Evaluations	Education Evaluations	Placement/Day Services	Behavioral Treatment Services	Medical Treatment Services	Education Services	Recreational Services	Adjunctive Services
All Programs	.0633	.4102	-.1784	-.4796*	-.1038	.4274	.1471	-.2869	.2563	-.0690	.5533*
Education Programs	-.3340	-.1469	-.1370	-.2853	-.3242	-.0759	.0842	-.1571	.2043	-.2850	-.1322
Health Programs	.2974	.3179	-.1545	-.0621	.2447	.2716	.2389	-.3968	-.0673	.2432	.3109
Mental Health Programs	.4506	.2709	.0911	-.2191	-.0641	.3538	.3546	.2848	-.0943	.2274	.3812
Child Welfare Programs (a)	.4388	.4669*	.1536	-.2165	NC	.3900	.3400	.2838	.3961	.2263	.7046**
Legal Programs (b)	.3982	-.0242	.1673	-.0246	.1484	.1888	.3560	.2061	-.4074	.2658	.0474

(a) Based on four delivery systems.
(b) Based on one delivery system.
* Indicates significant at <.05 level.
** Indicates significant at <.01 level.

post placement/day services that are frequently reimbursed at cost.

Two apparent exceptions to this scenario are the findings that (a) delivery systems with larger proportions of non-profit health programs were more likely to provide technology and profit oriented medical evaluation services, while delivery systems with larger proportions of for-profit health programs were less likely to provide these services; and (b) delivery systems with larger proportions of private non-profit mental health programs were less likely to provide non-technology and service oriented behavioral evaluation services. A possible interpretation of these findings is the possibility that the provision of both medical and behavioral evaluation services by the health and mental health programs might have been influenced by accreditation, regulatory, and/or internal programmatic requirements.

Finally, the study results raise several overlapping concerns/questions concerning the impact of auspice on the availability, as well as the comprehensiveness, of the services provided by the sample RTCs and their delivery system programs. Although, the total availability of delivery system services was fairly high (mean of 68%), a more detailed look at the data in Table 6 suggests that the availability of many delivery system services was somewhat fragmented, that is, system services ranged from a mean of 31% to a mean of 90% and tended to be concentrated in evaluation rather than non-evaluation services. For example, the educational, behavioral, and medical evaluation service category means of 87, 86, and 85% respectively, exceeded the

Table 9

Relationships Between Delivery System Private Program Auspice and the Availability of Delivery System Services

	Proportions of Available Services										
Delivery System Public Program Auspice	Total Services	General Evaluations	Behavioral Evaluations	Medical Evaluations	Education Evaluations	Placement/Day Services	Behavioral Treatment Services	Medical Treatment Services	Education Services	Recreational Services	Adjunctive Services
All Programs	-.0061	-.4047	.1868	.4718*	.0827	-.4314	-.1301	.2961	.2310	.0791	-.5639*
Education Programs	.2859	.2623	-.1014	.1836	.2160	.1774	-.3214	-.1436	.3032	.3867	.4557
Health Programs	-.2553	-.3342	.1832	-.0644	-.2343	-.2584	-.2134	.4441	.0238	-.2129	.3124
Mental Health Programs	-.2276	-.3177	.0135	.2267	.1731	-.2637	-.1499	-.1752	-.1747	-.0704	-.3912

* Indicates significant at <.05 level.
** Indicates significant at <.01 level.
Note: No child welfare or legal programs are listed on the table because these programs were not included in the sample.

behavioral treatment, educational, medical treatment, placement/post placement/day and adjunctive service category means of 74, 69, 67, 54, and 29% respectively, but did not exceed the recreational service category mean of 77%.

Also, while one might not expect to find a heavy concentration of child welfare and legal programs (and services) in delivery systems serving children with emotional disturbance, what seems to be the extreme lack of both these programs (and their services) in the study sample should be viewed with concern. The dearth of these resources raises questions regarding the attitudes of the delivery system

Table 10
Relationships Between Delivery System Private Non-Profit and For-Profit Program Auspice and the Availability of Delivery System Services

Private Non-Profit and For-Profit Delivery System Program Auspice	Proportions of Available Services										
	Total Services	General Evaluations	Behavioral Evaluations	Medical Evaluations	Education Evaluations	Placement/Day Services	Behavioral Treatment Services	Medical Treatment Services	Education Services	Recreational Services	Adjunctive Services
Non-Profit Programs											
All Programs	.1506	.0038	-.1675	.1769	.1250	.5586*	.3767	-.1736	.1461	.0096	.0483
Education Programs	.2732	.2471	-.1219	.1969	.2163	.1720	-.3287	-.1690	.2969	.3874	.4488
Health Programs	.2350	.0744	.0220	.5354*	.5150*	.5880 *	.1212	.1862	-.0379	-.1414	.1621
Mental Health Programs	-.1745	-.0885	-.4968*	-.2755	-.2155	.4210	-.0218	-.3199	.0706	-.2534	.3143
For-Profit Programs											
All Programs	-.1516	-.0730	.1255	-.3016	-.1697	-.5167*	-.3404	.0954	-.1280	.0477	.0110
Health Programs	-.2409	-.0568	-.0572	-.5279*	-.4981*	-.5583*	-.1403	-.2127	.0951	.1504	-.1293
Mental Health Programs	-.0302	.1006	.4099	.3048	.1431	-.5327*	-.1733	.1992	.1556	.1315	-.3436

* Indicates significant at <.05 level.

** Indicates significant at <.01 level.

Note: No non-profit child welfare or legal programs and no for-profit education, child welfare, and legal programs were listed on the table because none of these programs were included in the sample.

programs toward children's rights, services to poor and minority children, and the role of both the juvenile court and court related services in the provision of services to RTC program clients.

Concerning the comprehensiveness of the services provided by the RTCs and their delivery system programs, several points/questions need to be made/raised. First the study findings that indicated that delivery systems characterized by larger proportions of public auspice or private non-profit or for-profit auspice programs tended to provide different services (see Tables 8, 9, and 10) suggest that the systems did not provide a range of services to meet a variety of child/family needs. This is contrary to the recommendations of child welfare and mental health professionals that services to children with emotional disturbance should be both comprehensive and continuous (President's Commission on Mental Health, 1978; and Stroul & Friedman, 1986).

Second, the findings that (a) private non-profit RTC programs tended to work with either public or private non-profit delivery system programs, especially mental health programs, and (b) delivery systems dominated by either public, private non-profit, or private for-profit auspice programs tended to provide different kinds of services, raise questions concerning whether:

- The provision of services to children with emotional disturbance in the RTC delivery systems was two-tiered, that is, one tier dominated by either public auspice or private non-profit auspice programs and public/private non-profit sponsored services, and the other tier dominated by private for-profit auspice programs and private for-profit oriented services.
- The provision of future services to children with emotional disturbance in RTCs (given the current movement toward the increased use of for-profit auspice programs to serve this group) will focus on services to middle and upper-class children who have access to private insurance coverage, at the expense of poor and/or minority children who arguably will have to use whatever public auspice program services are available.

Conclusion and Implications

The exploratory study described in this paper investigated the impact of program auspice on the ability of *all* of the programs within a delivery system to provide services to children with emotional disturbance who were placed in RTC programs. The study results (a) supported the impact of auspice on the availability of adjunctive, behavioral evaluation, educational evaluation, medical evaluation, and placement/post placement/day services; and (b) raised concerns/questions regarding the availability and the comprehensiveness of the services provided to the children with emotional disturbance by both the RTCs and their delivery system programs.

In accordance with its exploratory nature, the auspice variable relationships described in the paper are very broad and do not reflect the complexity of the associations. Additional research to further investigate the impact of auspice on the delivery of services to children with emotional disturbance in RTCs, including the concerns/questions suggested by the study results, is needed.

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Appendix

Delivery System Service List

General Evaluations: Intake, Initial Master Individualized Treatment Plan (ITP), Periodic ITP Review, Initial Education Plan (IEP), Periodic IEP Review, Discharge ITP, Adoption Study, and Legal Custody

Status evaluations: Behavioral Evaluations: Activity Therapy Assessment, IQ Assessment, Occupational Therapy Assessment, Personality Assessment, and Psychosocial Assessment evaluations.

Medical Evaluations: Alcohol/Drug, Dental, Immunization, Lab Test, Mental Status, Motor Development, Functioning, Neurology, Nutrition Assessment, Physical Examination, and Psychiatric evaluations.

Education Evaluations: Audiology Assessment, Language Skill Assessment, Math Computation Assessment, Reading Level Assessment, Speech Assessment, Visual Examination, and Vocational Skills Assessment evaluations.

General Placement/Post Placement/Day Services: Aftercare/Follow-up, Daycare, Day Treatment, Foster Home Placement, Group Home Placement, Outpatient Treatment, Respite Care Placement, Therapeutic Foster Home Placement, and Therapeutic Group Home Placement services.

Behavioral Treatment Services: Behavior Management System, Case management, Crises Intervention, Family Therapy, Music Therapy, Restraint, Self-help Training, Seclusion Room, Social Skill Training, Reality Therapy, and Time Out Room services.

Medical Treatment Services: Dental, Dietetic, Drug Education, Drug Therapy, Electroconvulsive Therapy, and Pathology/Laboratory services.

Education Services: Audiology, Language Skill Training, Regular School Class, Special School Class, Speech Therapy, Tutoring, Vocational Counseling, Vocational Training, and Art/Music/Drama Class services.

Recreational Services: Art, Camping, Craft, Cycling, Dancing, Music Related Activity, Reading, Swimming, and Television Services.

Adjunctive Services: Adoption, Babysitting, Family Housing, Financial Advice/Aid, Foster Grandparent, Homebound, Homemaker, Home Visit, Information/Referral, Legal, Shopping Trip, and Transportation services.

Resource Transfers Between Agencies Caring For Children's Mental Health: A Panel Study Of Embeddedness

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Do agencies interact like autonomous buyers and sellers in a market with spot-exchanges driven by supply and demand? Or do agencies enact roles of authority and subordinates governed by mandates, contracts and agreements, like commands within an organization? Or are the transactions a mixture of market and command? Or are they neither market nor command, but a networked system in which resource transactions are embedded in informal working relations? These questions are approached through a survey of the transfer of resources such as funds, information and clients and other working relations between the agencies in systems of services for youth with serious emotional disturbances. The various kinds of resource transfers were found to be affected by different conditions. Specifically, an agency's acquisition of information from another agency is enhanced by the perceived effectiveness of the relationship between them, by the similarity of their service domains, and by their communication; an agency's client referrals from another agency are promoted by domain similarity, by communication, and by access, but not by the acquisition of funds from the other one; and an agency's receipt of funds from another agency is increased by the perceived effectiveness of their relationship; and all of these are effects reshape transfers.

Market, Command, and Embedded Transactions

Services for youth with serious emotional disturbances are provided by agencies. Agencies do not provide services in isolation from one another. Typically, each agency is specialized in providing one kind of service, but a child with a mental illness requires several kinds of services in a continuum of care and therefore may be serviced by several agencies. There is a division of labor in service provision among the agencies. They transact with one another. For example, clients are referred to one agency by another, information is sent to one agency from another, and funds are obtained by one agency from another for serving children. Through this transfer of resources and other relations a system emerges. The linkages are not only the glue among the agencies, they are the building blocks of the system.

How can the transactional patterning of the system be described? Analysts examining the social patterning of an activity have traditionally sought to describe the social arrangements of an activity as either a market or as a bureaucratic hierarchy. If neither of the two descriptions is fitting, analysts describe the social patterning as a mixture of

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market and hierarchy. But can a system of services be described as somewhat like a market, organized by discrete on-the-spot exchanges between autonomous agencies, driven by supply and demand, and unaffected by other relations among the agencies in the market? A pure market might conceivably be approximated in a community where persons with mental illnesses have complete and sole control over own money,and say, vouchers and shop around for services.

Or can a typical service system be described as somewhat of a command hierarchy similar to the governance within a firm, organized by command, mandates and contractual transactions, driven by an authority at the top and down through chains of subordinates? Such a pattern may be found in a highly centralized system governed by a central mental health authority, such as that which is promoted in the program initiated by the Robert Wood Johnson Foundation for services for chronically mentally ill adults in several cities around the United States (Goldman et al., 1990).

If the typical system is neither like a market nor like a command hierarchy, is it then a mixture of market and hierarchical transactions? Or is the typical system of a third form, quite distinct both from market exchanges and from hierarchical commands, a web of rather informal and ongoing working relations among agencies? This form of transaction has been forcefully argued to obtain among organizations in general (Powell, 1990), especially among social service agencies (Alter & Hage, 1993), and in particular among mental health agencies (Burgess, Nelson, & Wallhaus, 1974; Grusky et al., 1986; Hage, 1986; Morrissey, Tausig & Lindsey, 1986; Morrissey, Hall & Lindsey 1992; Scott & Blake, 1986).

A typical mental health service system may be neither like a market nor like a hierarchy. It may be more like a web in which a relationship is a bundle of regular but informal communication, cooperation, collaboration and coordination based on complementary strengths, trust and expectations of reciprocity between interdependent agencies (Schott, 1989; 1992). The relationship between agencies differs from the hierarchical command between an authority and a subordinate insofar as agencies have autonomy. The exchange between agencies differs from the discrete encounter between independent actors on a pure market insofar as exchange is embedded in a broader bundle of relations between agencies that variously enable and constrain their exchange (Granovetter, 1985). The relationship between agencies is a bundle of specific kinds of relations, analytically distinct contents of the relationship (Burt & Schott, 1989). These substantive contents are analytically distinguishable from one another but are intertwined in reality and form a bundle in the relationship between the agencies.

The relationship can be examined if we first make analytic distinctions among various contents and then observe the extent to which each content is present in a relationship. A content may be a resource, notably funds, clients and information, that is transferred from one agency to another. Other kinds of working relations between agencies include the agency head's personal friendships within the other, the agency head's perception of the effectiveness of its cooperation with the other, the consensus between the agencies, and the negotiated and formalized agreement that might exist between them.

To answer the general question of whether transactions among mental health agencies in a community are like a market, like a command hierarchy, or like a networked system, this analysis focuses on the salient relations between agencies, i.e., the transfer of resources. The phenomenon of resource transfers needs to be described in terms of prevalence and the co-occurrence of various kinds of resources. How intense are transfers of resources from one agency to another, notably information, clients, and funds? Are these resources received as a bundle or separately? The next questions focus on the dynamics of change. Is the agency's receipt of information from another agency enhanced or reduced by other working relations?

Is the agency's receipt of clients from another agency enhanced or decreased by other working relations? Is the agency's receipt of funding from another agency reinforced or hampered by other working relations?

Data on Relationships Among Agencies

In addressing the question of how resource transfers are structured and embedded in other kinds of relations, data were gathered from a panel survey of relations among the agencies in two communities which provide mental health, juvenile justice and supportive services for children and youth. The two communities, Onondaga and Orange counties in upstate New York, were surveyed for the New York State Office of Mental Health in fall 1986 and again in spring 1988 (Morrissey & Schott, 1991). In each community a panel of local experts determined which agencies (the term "agency" here includes, in a few instances, a unit within a larger organization) made up the system of providers of services for children and youth with mental health problems. Orange had 21 agencies and thus up to 420 (21 x 20) linkages from one agency to another, while Onondaga had 32 agencies and thus up to 992 (32 x 31) actual linkages from one agency to another. Thus, there were a total of 1,412 (420 + 992) possible linkages among the agencies. These relationships constitute the "universe" or "population of elements" for study. The population of relationships was surveyed. In each agency a key informant, a director or other head, responded to a questionnaire tapping transfer of resources such as funds, clients and information, and other specific kinds of relations with every other agency within the system. The questionnaire was developed and validated by Van de Ven and associates (Van de Ven & Ferry, 1980) for relations among organizations of any kind and was adapted specifically for relations among mental health agencies by Morrissey and colleagues (Morrissey, Hall, & Lindsey, 1982; Morrissey, Tausig, & Lindsey, 1985).

Specifically, I shall analyze the following contents as variables measured on each relationship from one agency to another. Firstly, the three kinds of resource procurements:

Information is the agency's receipt of information from the other agency, measured on an extent scale (the extent scale goes from 'none' through 'little', 'some' and 'much' up to 'great' extent);

Clients is the agency's receipt of clients from the other agency, measured on an extent scale; and

Funds is the agency's receipt of funds from the other agency, measured on an extent scale.

These three resource procurements are expectedly variously embedded in and thereby variously enabled and constrained by the following kinds of working relations:

Communication of the agency with the other agency is an unobserved variable that has three indicators, namely face-to-face exchanges as measured on a frequency scale, telephone calls to the other agency on the same frequency scale, and written correspondence to the other agency on the frequency scale (the frequency scale goes from 'not once' through 'a few times', 'once a month', 'twice a month', 'weekly' and up to 'daily'):

Consensus of the agency with the other is an unobserved variable that has two indicators, namely consensus on services needed by children with mental health problems, and consensus on the services that should be provided by the agency, both or which are measured on the extent scale:

Domain-similarity refers to the two agencies working in the same domain, which is measured as 1 if both are in the mental health service domain or both are in the criminal justice domain, and 0 if otherwise;

Shared facilities between the two agencies is an unobserved variable that has three indicators, namely shared staff, shared space, and shared equipment, each measured on the extent scale;

Joint organization refers to the two "agencies" being units within the same organization, measured as 1 if they are units within the same organization, and 0 if otherwise;

Contact refers to the agency head having a personal contact in the other agency, which is measured as 1 if this is present, and otherwise as 0;

Effectiveness of the agency's relationship with the other agency is an unobserved variable that has four indicators, specifically the productiveness of the relationship with the other agency, worthwhileness of the relationship, satisfaction with the relationship, and commitment of the other agency to carry out its obligations in the relationship, where each of the four is measured on the extent scale;

Access is the ease with which the agency has in contacting the other agency, and is measured as the reverse of the response to a question of how difficult it is to get in touch with the other agency when needed;

Agreement between two agencies refers to having a formalized agreement, and is measured as 1 if an agreement exists, and 0 if otherwise.

Most items have satisfactory measurement properties in a complete enumeration of relationships in a system as assessed by factor analyses of the data. These factor analyses entailed some modifications to earlier constructions of variables by multiple indicators (Van de Ven & Ferry, 1980; Schott, 1992).

The unit of analysis is the relationship from a key informant's agency to another agency. To answer the above questions, the data can be analyzed by univariate statistics such as percentages and by multivariate techniques such as multiple regression or, better, LISREL modeling of unobserved variables with several measured indicators. The relationships, though, are not statistically independent cases, since many relationships are anchored on the same agencies, and, in particular, the relationship to one agency from another agency is treated as a case distinct from the case consisting of the relationship to the latter from the former. Therefore usual procedures of statistical inference cannot be used. Rather than focus on statistical significance, I will mainly employ criteria of substantive significance and focus on ascertaining magnitude of effects, specifically on enhancing or reducing effects upon resource procurement from other working relations.

How the transfer of a resource between agencies is affected by other kinds of relations can be examined by methods of analysis of multiple variables, i.e. a multivariate analysis. Notably, the measured transfer of a resource may be a function of the measures of other kinds of relations. But in so far as the various kinds of relations are intertwined as a bundle, they are likely to affect one another, to reinforce and constrain one another. Notably, no study has reported a unidirectional cause and effect association among kinds of relations. Rather, kinds of relations feed back on each other. Therefore analysis of data at a single point in time may be misleading. Panel data with measures at repeated points in time may distinguish cause and subsequent effect (Van de Ven & Walker, 1984). Therefore a suitable procedure is to treat the resource transfer at a late time point as a function of other relations at an earlier time point, and to control for the resource transfer at the early time point so as to assess the separately enhancing or reducing effect of the other relations on the resource transfer.

Prevalence and Co-Occurrence of Kinds of Resource Transactions.

The phenomenon of resource procurement, specifically funds, clients and information, shall here be described in terms of the prevalence of each kind and the co-occurrence of several kinds of resource procurement.

Funding was procured in 6% of the possible relationships; that is, on average, an agency received funds from 6% of the other agencies in the system. Clients were received in 60% of the possible relationships, which information was acquired in 70% of the possible relationships. Thus, funding procurement occurred rarely while the transfer of clients and information prevailed in more than half of the possible relationships. This high density of resource transactions shows that the service delivery system is actually quite tight knit.

Only 28% of the possible relationships involved no receipt of any of these resources. As many as 72% involved receipt of at least one kind of resource. More specifically, 5% involved receipt of all three resources, 52% involved receipt of two kinds of resources (51% involved information and clients, 1% involved information and funding, and 0% involved clients and funding), and 15% involved receipt of one kind of resource (12% involved only information, 3% involved only clients, and 0% involved only funding). Thus, procurement of funds mainly occurs together with procurement of information, and clients and referrals of clients mainly occurs together with acquisition of information.

Embeddedness of Resource Transfers in Other Working Relations

Procurement of resources is rather unstable. Funding, client referrals and information transfers are likely to vary considerably over time. The correlation between funding at one point in time and about 18 months later is .33. The correlation between client referrals at the two points in time is .34, and the correlation between information flows at the two times is .35 (Please note: the analyses in this section ignore the possible linkages for which no transactions were reported at both time points and also the relationships with missing values. Thus, the computations in this section are based on an N of about 800 relationships). These reports are likely to contain much measurement error (Marsden, 1990), but the correlations are still surprisingly low, suggesting that considerable systematic change has occurred.

If, indeed, systematic change has occurred then we should be able to account for the change as enhancing or dampening effects from some other conditions, notably from other working relations.

Is funding to one agency from another agency enhanced or reduced by other working relations? The effects upon funding at the second time point may be modeled as a function of earlier working relations with a control for funding at that earlier time point. The other working relations are those listed above. Their separate effects can be estimated as standardized coefficients in a linear model. If each kind of working relation were measured, then a multiple regression model would be the preferred technique. Here, however, a relation such as the effectiveness of the linkage was not measured directly, but is an unobserved variable with several measured indicators, and in this situation the preferred modeling is LISREL which estimates coefficients in a linear model, similar to the regression coefficients in the usual multiple regression model (Joreskog & Sorbom, 1989). Nearly all working relations turned out to be quite negligible and were dropped from the model. Apart from the control for funding at the early time point, only effectiveness turned out to be of importance as shown by the standardized coefficients.

$$\text{Funds}_2 = .30\ \text{Funds} + .11\ \text{Effectiveness}$$
$$(R^2 = .12)$$

This shows that effectiveness, the perception in an agency of the effectiveness of its relationship with another agency, enhances subsequent procurement of funding by the agency from the other one.

Is the information that an agency obtains from another agency enhanced or reduced by other working relations? As with funding, the effects on information acquisition from other kinds of working relations can be ascertained by modeling information at a second time point as a linear function of other working relations with a control for information at the early time point. Most working relations turned out to be quite insignificant and, apart from information at the early time point, only effectiveness and communication turned out to be important, as shown by the standardized coefficients.

$$\begin{aligned} \text{Information}_2 = {} & .22 \text{ Information} \\ & + .18 \text{ Communication} \\ & + .09 \text{ Effectiveness} \\ & (R^2 = .16) \end{aligned}$$

Information is of course acquired through communication and therefore the two are correlated, but it is not this banality that is expressed in the resulting equation. The equation shows that intense communication has a subsequent reinforcing effect on information transfer, over and above the existing flow of information. Likewise, effectiveness has an enhancing effect on information transfer, as was shown in procurement of funds.

Are client referrlas from one agency to another enhanced or reduced by other working relations? Client referrals can be modeled as a function of earlier client referrals and other working relations. Some kinds of working relations were found to have no effect, but several have notable effects, as shown by their standardized coefficients.

$$\begin{aligned} \text{Clients}_2 = {} & .18 \text{ Clients} \\ & + .25 \text{ Communication} \\ & + .12 \text{ Access} \\ & + .08 \text{ Sharing} \\ & - .15 \text{ Funds} \\ & (R^2 = .18) \end{aligned}$$

This illustrates that client referrals to an agency from another agency are enhanced by communication, by the access that the agency has to the other one, and by sharing facilities with the other agency, and these relations exert effects over and above the existing client referrals. Conversely, the dependence of the agency on funding from the other one entails a reduction in the referral of clients from the agency to the other one. This effect may be counterintuitive at first sight. I surmise that the effect may be due to the volatility of funding and its actual coupling with client referrals in that some of the funds at the early time point may be cut, and therefore client referrals that had been coupled to the funds are also declining. Thereby the coupling of clients and funds may actually account for the negative effect of funding at the early time point on subsequent client referrals.

These analyses show several dynamic effects upon resource transactions from other working relations, notably from informal working relations. The formalization of an agreement was not a condition significantly affecting resource flows.

Conclusions

The major issue behind the concrete analyses is the question of whether the transactions among agencies are like a market, like an organization, or like a networked system. First, the analyses have shown that while funding transactions are sparse among service agencies, transfers of clients and information are quite dense among the agencies, so that agencies are tightly knitted to one another. Second, the transactions of each resource are not a spot-exchange that occurs independent of other working relations. Rather, resource transactions, whether involving funds, clients or information, are embedded in other ongoing but informal working relations that variously reinforce or reduce the resource transfers. Embedding implies that the agencies are not like autonomous spot-exchanging buyers and sellers in a supply and demand driven market. The result that the resource transactions tend not to be embedded in mandated, contractual, or formalized linkages implies that the transactions are not like the command hierarchy within an organization. Rather, the embedding of resource transactions in rather informal working relations between agencies shows that the agencies form a networked system.

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Cash Subsidies: Meeting the Needs of Families with Children with Developmental and Emotional Disabilities

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Cash subsidies for families caring for children with disabilities are gaining support both in theory and in practice. These family-centered initiatives are aimed at defraying the extraordinary costs associated with the child's care and preventing out-of-home placements. Since 1990, Illinois began providing cash assistance for families of children with severe emotional disturbance and children with developmental disabilities. Evaluation findings from a two-year longitudinal study using family and child characteristics, service needs, level of stress, family support network, and out-of home placement plans are presented. Particular attention is paid to program impacts and ways in which the families utilized the money. Drawing from the Illinois experience, policy implications of using a cash subsidy model are also discussed.

Introduction

Cash subsidies or family care grants, which offer financial assistance to families who are raising a child with a disability, are increasing both in theory and practice. In 1988, approximately 20 states offered cash assistance to families who were raising a child with developmental disabilities (Agosta, Langer-Ellison, & Moore, 1988). By 1990, the number had risen to 25 states (Knoll, Covert, Osuch, O'Connor, Blaney, & Agosta, 1990). A discretionary cash subsidy model is a departure from traditional family support programs in several ways. First, this model recognizes the fact that caring for children with special needs have inherent costs which are specific and unique to the individual family. Unlike a service provider model where parents are offered a predefined package of services which may or may not fit their needs, a cash subsidy model gives families the opportunity to prioritize needs and exercise responsible decisions in planning for the care of their child. Second, with emergence of family-centered programs, there is a shift in focus to meeting the needs of the family rather than focusing on the child as the target of intervention (Friesen & Koroloff, 1990). This focus carries with it the assumption that meeting the overall needs of the family will indirectly benefit the child with the disability. Third, the cash subsidy model allows families to meet the needs of their child and carry on daily routines in a more normalized way (Singer & Irvin, 1988).

Historically, family support programs were targeted at families of children with developmental disabilities and only recently are similar programs for families of children with emotional disabilities being developed (Freud, 1989). With the signing of the Family Assistance Law in 1990, Illinois became the first state to include families of children with severe emotional disturbance in their cash subsidy program. The Illinois Family Assistance Program, a cash subsidy model, is targeted at a small number of families of children with severe emotional disorders (SED) or severe developmental disabilities (DD). The goals of the program are to empower families in meeting the special needs of their child and to help maintain these children in the family home. This paper examines the longitudinal effects of the program on the care associated with children with disabilities, the families' use of existing community resources and their decisions regarding out-of-home care approximately one year after the program began.

Methodology

Four basic criteria were used to determine eligibility into the program: 1) the family must have a taxable income level below $50,000; 2) the child must have a severe emotional or developmental disability; 3) family must be a resident of Illinois; and 4) the child must reside in the family home. Families were randomly selected into two groups: families receiving the subsidy and an alternate or comparison group of families.

Two family surveys were administered during the first year, approximately nine months apart, to participating and alternate families. The family surveys were developed to assess six areas of interest: 1) the use of existing community resources and informal supports; 2) information about the child's medical/therapeutic and educational status; 3) the level of stress and adaptation (Stein & Riessman, 1980); 4) family identification of need (Dunst, Trivette, & Deal, 1988); 5) out-of-home placement plans; and 6) the use of the stipend. Additional data, such as demographic characteristics and the number of vouchers received were obtained from the Illinois Department of Mental Health and Develop-mental Disabilities (DMHDD).

From the data, four questions were asked: 1) How did the subsidy influence the families' decision for out-of-home care? 2) To what extent did the subsidy affect the families' level of need? 3) Did the subsidy ease the burdens or reduce the stress associated with the care of their child? and, 4) How was the subsidy used to meet the families' needs.

Sample Characteristics

A total of 302 families completed Time 1 and Time 2 surveys. The majority of respondents were families receiving the stipend (n = 195, 64.4%). The remaining 107 alternate families were used in the analyses as a comparison group. Of the families who participated in the study, 78% (n = 236) were mothers; 9.6 % (n = 29) were fathers; 4.6 % (n = 14) were grandmothers; and, the remaining 7.6% were other respondents such as foster parents, stepparents or siblings. Approximately, 60% of the families were two-parent households and 33 % were one-parent households. The mean age for the children in the sample was 10. Children with SED were significantly older than the children with DD ($\bar{X}$=11.33, sd = 3.41; $\bar{X}$ = 9.67, sd = 4.26, respectively).

Results

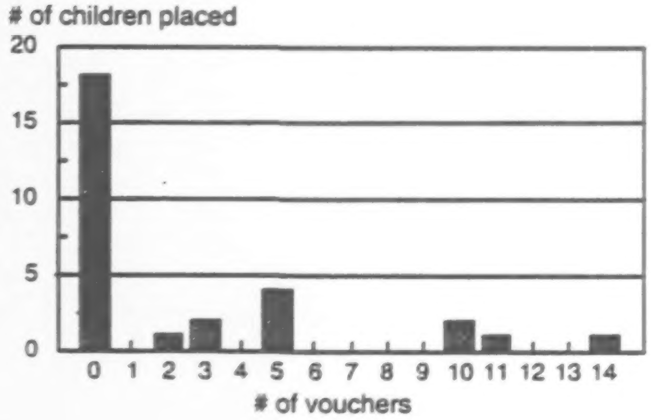
The first question which examined the families' decision for out-of-home care is complex and often precipitated by factors not available to the researcher. Using a multiple regression, it was found that the decision to place a child outside of the home was associated with families who were less connected with a support system, families who felt more stress concerning their child and reported a higher level of overall family need. Additionally, families who indicated that they were considering an out-of-home placement had children who were significantly older than families who were not.

With respect to program participation, it was found that the Family Assistance Program has been helpful in preventing or forestalling out-of-home placements. Children not receiving stipends had a higher rate for out-of-home care than children whose families were receiving the subsidy. During the first year, 29 children were placed in residential care; 18 of those children (62%) were from the alternate list. Figure 1 illustrates the children who were placed by the number of vouchers they received.

A second set of analyses was conducted to determine if parents' decisions regarding out-of home care changed over the course of the first year. This was done by computing a risk indicator from the out-of-home care responses listed in the survey. For example, if a parent indicated that they were not planning out-of-home care at Time 1 but were anticipating out-of-home care at Time 2, the child's risk increased. Conversely, if a parent indicated that they were planning out-of-home care at Time 1 but were not anticipating out-of-home care at Time 2, the child's risk decreased. An analysis of variance was conducted to determine if the number of payments affected the risk factor. The results demonstrate that families receiving the subsidy were more likely to decrease their desire to consider out-of-home placements than families not receiving the subsidy.

Figure 1

Number of Children Placed by Vouchers Received



The second question examines which factors were associated with the overall level of need and if the subsidy had a positive effect in reducing the level of reported need over time. The level of family need was strongly correlated with the amount of stress associated with the care of the child. Families who reported a high level of need reported a high amount of stress. This was true for both diagnostic groups. No differences were found between the level of family need and diagnosis. The level of family need was significantly associated with household composition. Single-parent households reported a higher level of need than two parent households. With respect to the receipt of the family subsidy and the change in need, there was no significant difference in overall family need from Time 1 to Time 2 for families receiving the subsidy.

Similar to the second question, the third question examined which factors were associated with the levels of stress and if the receipt of the subsidy had a positive impact on the reduction of stress. Family need, income, and the need for community services were predictors of the stress associated with caring for a child with disabilities. There were no differences between the two diagnostic groups. The receipt of the subsidy did not effect the level of stress and no differences were reported between Time 1 and Time 2 between the two program groups.

The fourth and final question examined out-of-pocket expenses and the use of the subsidy to meet the special needs of the child. The next set of analyses was conducted to compare differences on expenses between the two diagnostic groups across nine categories of needs. The results, listed in Table 1 indicate that families of children with developmental disabilities spent more of their financial resources to meet the needs of their children in areas of home modifications and adaptive equipment than families of children with SED. Families of children with emotional disabilities spent more of their financial resources on information and parent training and recreational activities than families of children with DD.

In other words, the needs of families of children with DD seemed to be concentrated on things related to easing the physical challenges associated with the care of the child (e.g., adaptive equipment) while the needs of families of children with SED seemed concentrated on easing the emotional care of their child or providing ways to occupy their time such as recreational activities.

A second set of analyses was conducted to compare differences on expenses between the two program groups across nine categories of needs. The fourth and final question examined out-of-pocket expenses and the Families not receiving the subsidy reported more expenses in eight of the nine categories of need. As seen in Table 2, they spent significantly more of their financial resources on medical expenses (e.g., medical/dental care, medications, and therapy), support services (e.g., parent groups and community activities) and transportation costs than families receiving the subsidy.

Finally, a series of questions were asked of the receiving families regarding satisfaction with the program. As expected, families receiving the stipend were very satisfied with the program; 84% thought the amount of the subsidy was adequate, 73 % indicated that the stipend had eased their financial worries, and 79 % felt the stipend improved their ability to care for their child with the disability. Single parents reported greater satisfaction with the program than two-parent households.

Table 1
Comparison of Expenditures Between the Two Diagnostic Groups

Composite Score		DD		SED		Student's *t*
	Range	*N*	$\bar{X}$	*N*	$\bar{X}$	*p* <
Home Renovations	0-4	237	0.59	64	0.33	.01 *
Adaptive Equipment	0-7	237	1.32	64	0.96	.00 *
Basic Necessities	0-6	237	2.69	64	2.67	.94
Recreation Activities	0-5	237	1.09	64	1.57	.00 *
Respite Care	0-8	237	1.41	64	1.41	.99
Information & Parent Training	0-7	237	0.65	64	1.72	.00 *
Medical Expenses	0-12	237	3.02	64	3.06	.91
Support Services	0-5	237	0.43	64	0.51	.49
Transportation	0-6	237	1.42	64	1.15	.13

Table 2
Comparison of Expenditures Between the Two Program Groups

Composite Score		Selected		Alternate		Student's *t*
	Range	*N*	$\bar{X}$	*N*	$\bar{X}$	*p* <
Home Renovations	0-4	195	.51	107	.58	.48
Adaptive Equipment	0-7	195	1.05	107	1.32	.07
Basics	0-6	195	2.62	107	2.78	.50
Recreation Activities	0-5	195	1.27	107	1.07	.17
Respite Care	0-8	195	1.38	107	1.44	.68
Information & Parent Training	0-7	195	.85	107	0.92	.64
Medical Expenses	0-12	195	2.73	107	3.56	.00 *
Support Services	0-5	195	.37	107	.58	.04 *
Transportation	0-6	195	1.18	107	1.67	.04 *

Summary

During the first year, the evaluation has shown that the Illinois FAP seems to have had a positive effect in preventing and forestalling out-of-home care. This represents a substantial savings to the state in residential care. Moreover, it represents a savings in the human costs associated with the disruption of the family unit. With the help of extra financial assistance, families seemed better able to continue to care for their child in the most natural setting.

Reduction in overall family need or stress did not occur during the first year of the program for families receiving the subsidy. This may have happened for several reasons. First, factors such as the level of need and stress have been present in the lives of these families since the onset of the child's diagnosis and his or her need for special care. Consequently, ten months may be too short to notice and significant change. Noticeable improvement of the family's quality of life and reduction of on-going stress may require longer program participation. Second, methods to measure these concepts are rudimentary at best and qualitative information from the families may be more sensitive for examining program outcomes (Weissbourd & Kagan, 1989).

In summary, the parents' need for personal time consistently remained unmet. This issue seems to go beyond the need for the often inadequate or unavailable periodic relief found in respite care and perhaps is more closely tied to the chronic day-to-day need for personal time. The use of a cash subsidy may not address the particular need and other supports such as respite care may be an equally necessary support.

Discussion

There is a lack of consensus regarding the administration of family support programs. Policy makers are puzzled by decisions regarding the magnitude of services, the types of services and how these services are best delivered. These decisions are further complicated with a cash subsidy program where the individual family is the administering agent.

Supporters of a cash subsidy model maintain that such a program offers parents the flexibility to meet their unique needs rather than offer a package of predefined services which may not meet their needs. Second, such a program is less costly than direct service programs and easier to administer. Finally, a cash subsidy model promotes a positive attitude toward the families' ability to tend to their own needs and making responsible decisions.

Opponents of the program are skeptical of the outcomes and argue that such a program creates dependency. Moreover, they question the families' judgment about their use of the stipend and feel they may use the money for items not related to the care of the child.

The findings from the Illinois study are obtained from a twelve month period of time for a relatively small number of eligible families. The results seem to suggest that the program is successful in preventing out-of-home care. However, other outcomes such as a reduction in stress or a reduction in family need have not yet been demonstrated. Additionally, there is some evidence to suggest that the presence of extra financial resources does not meet all of the families' needs and that optimal outcomes are achieved when financial resources are supplemented with additional supports both formal and informal. In conclusion, a cash subsidy program for families of children with disabilities must be seen as part of a larger family support system. A sound infrastructure of other equally important supports such as recreational programs and respite care along with the coordination of services from other systems (i.e., education and medicine) are needed to achieve optimum outcomes.

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Program Evaluation

Chapter 3

A Comparison Of Children's In-Home Psychiatric Emergency Services: Service Design and Research Plan

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Introduction

During recent years, the number of children and adolescents presenting at psychiatric emergency programs has increased (Rosenn, 1984). In New York State, 55,744 children presented in emergency rooms and crisis settings in 1989. Often, this represents a final effort by families to receive care that is desperately needed, has not been accessed elsewhere, and may unnecessarily result in a stigmatizing and costly inpatient placement.

Little is known about either the characteristics and service needs of youth presenting in psychiatric emergency settings or about the comparative outcomes associated with different models of psychiatric emergency care. Through a National Institute of Mental Health (NIMH) children's research demonstration grant, the New York State Office of Mental Health (OMH) is comparing the outcomes of three in-home psychiatric emergency programs when all three programs exist in the same urban community. The study also examines which children and families experience the best outcomes with each service model. This article summarizes the three service models, presents comparative data on children served statewide in psychiatric emergency programs and children served in other community-based programs, describes the community in which the demonstration will occur, reviews the research design, and describes the role of the Hispanic Research Center (HRC) in the research grant.

New York's guiding principle in the development of the children's emergency service system is that every child in psychiatric crisis and their family should have access to emergency services that provide comprehensive assessment, stabilization, and, if necessary, treatment and referral. The system must contain a wide array of service options and be available to families in their homes and in the community. Emergency rooms need access at all times to child mental health specialists as well as to diversionary crisis and family support services. These services include mobile crisis teams, crisis residential options, home-based crisis intervention programs, and access to local acute care child and adolescent inpatient psychiatric units.

A key component of New York's children's emergency system is the Home-Based Crisis Intervention (HBCI) program, a family preservation initiative designed to prevent the unnecessary inpatient hospitalization of children and youth. The program goal is to prevent psychiatric hospitalization by offering short-term, intensive in-home intervention services to a family with a child at imminent risk of being admitted to a psychiatric inpatient program. HBCI is based on the Homebuilders program, originally developed to serve families in which a child was at risk of out-of-home placement due to abuse or neglect.

Essential elements of HBCI are:

- Acceptance of only those families on the verge of having a child removed from their home as a result of a psychiatric crisis;
- A short-term crisis oriented intensive intervention that is provided as soon as possible, but no later than 24 hours after referral to the program;
- Flexible staff hours, including 24-hour response capability;
- An intake and assessment process designed to ensure that no family is left in a dangerous situation;
- An approach to intervention that focuses on the family, both its strengths and its needs;
- An approach that is multi-faceted including skills building, counseling and concrete services;
- A small caseload with each counselor working with only two families at any one time;
- Brief duration - usually four to six weeks;
- Linkage of family with ongoing family support services, (i.e., respite, support groups), intensive case management (ICM), clinic and day treatment programs;
- Follow-up with families both to assess their progress and to evaluate the program's success.

The target population for HBCI is families with a child or adolescent ages 5 to 17 years of age who is experiencing a psychiatric crisis so severe that unless immediate, effective intervention is provided, the child will be admitted to a psychiatric inpatient program. Family members must recognize that the child is in imminent danger of being removed from the home, agree to in-home services, and agree that significant changes must take place at once. The entry point to HBCI services is through either a psychiatric hospital or a psychiatric emergency room in a general hospital. Agencies with whom New York State has contracted to provide HBCI must have a linkage agreement with a hospital that offers children's psychiatric emergency services.

Each HBCI program is staffed by a crisis team consisting of a supervisor and four counselors. A single counselor enters the home as soon as possible within the next 24 hours after the psychiatric emergency program has referred the family, screens the family to determine eligibility, and receives verbal and written consent from the family to participate in the program. The counselor remains in the home with the family until the immediate crisis is resolved and under control. Given the in-home intrusive nature of the service, each counselor is trained to be responsive to individual family needs and daily routines. Once the immediate crisis has abated, the counselor and family develop goals and discuss what immediate tasks will be undertaken. The counselor teaches and monitors new, more effective parenting skills and negotiation skills, educates the family on the use and effects of psychiatric medication, and helps the family develop support networks, services, and resources. Intervention techniques include problem solving, goal setting, skill acquisition, family conflict resolution, and conflict management.

The expected duration of service is 4 to 6 weeks. During the first session with the family, the counselor and family establish discharge expectations. Each week the counselor summarizes with the family the progress made toward goal attainment and sets goals for the following week. During the last session, the family is encouraged to contact the counselor if there are reoccurrences of problem behaviors or crises after discharge. The family is also linked with appropriate services, including clinic treatment programs, intensive case management, and family support services.

Since January 1990, OMH has used a standard set of data collection instruments to collect descriptive information on all children served in a variety of community-based programs. A Client Description Form (CDF; completed within 30 days of admission to a program) elicits information on the child's basic demographic characteristics, referral source, diagnosis, current living situation and educational placement, functioning status, behavioral symptomatology, and mental health treatment and out-of-home placement history. A companion Program Termination Form (PTF) is completed upon discharge and collects information on date of discharge, living situation at discharge, and post-discharge service referrals. Analysis of these data provide a description of who is served by programs and whether the appropriate target population is being served. This presentation is based on a total of 2,307 youth: 1,796 in community-based programs, and 511 in HBCI.

On average, the typical child enrolled in HBCI is a 12-year-old, white (72%), non-Hispanic (81%), male (62%). He is in the custody of his biological or adoptive parents (91%) and is educated in an age-appropriate classroom setting (52%). On average, these children display 4.5 behavioral problems at admission. Most frequently reported symptoms are suicidal ideation (64%), depression (54%), physically aggressive (47%), temper tantrums (42%), dangerous to self (38%), anxiety (36%), dangerous to others (35%), and destruction of property (34%). Of the children who have been discharged from HBCI, 88% continued living in family situations (81% with a biological parent, 1% with an adoptive family, and 6% with a relative). Twelve percent (12%) lived in more restrictive settings upon discharge.

Analysis of the data from the CDF's indicates that the HBCI children are different from those

Figure 1
The Typical Child Served
by HBCI

- is 12 years old, white (72%), non-Hispanic (81%) & male (62%)
- is in the custody of a natural/adopted parent (91%)
- lives in a single parent household (60%)
- has Medicaid coverage (43%)
- is in an age appropriate classroom setting (52%)
- on average, displays 4.5 problem behaviors and symptoms
- on average, has been out of home due to psychiatric impairment 0.5 times
- on average, is functionally impaired in 2.0 areas

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served in community-based programs (See Figure 2). In general, many of the HBCI children do not display the duration or the severity of psychiatric symptoms, although they are in acute psychiatric crisis. Fewer have a history of psychiatric inpatient admissions or foster care placements. Far more HBCI children are in the custody of their biological/adoptive parents, and fewer are in a special educational placement. Compared to other community-based programs, Home-Based Crisis Intervention is an expensive, intensive program, and one question raised is: Can some of the children presenting at psychiatric rooms be diverted from inpatient admission by a less intensive, less expensive in-home program? If so, which children are they, and what services do they need?

Our quest to answer these questions lead to the development of a research and demonstration grant application "Outcomes of Three Psychiatric Emergency Programs for Children" that was recently funded by the National Institute of Mental Health (NIMH). The aims of this research are to establish two new in-home psychiatric emergency programs, Enhanced Home-Based Crisis Intervention (HBCI+) and Crisis Case Management (CCM), and to compare the outcomes of these programs with those of HBCI when all three programs are operating in the same urban communities in the Bronx.

Figure 2

Comparison of Children in HBCI and Community-Based Programs

Characteristic	Program Type	
	HBCI (*N* = 511)	Community-Based (*N* = 1,796)
Inpatient Admission	18.2%	62.1%
Foster Care Placement	6.4	25.0
Special Education Classification	22.7	58.9
Custody Status		
(Bio/Adopt Parents)	91.1	76.5
Presenting Symptoms		
Mean	4.9	5.5
SD	3.1	2.8
Prior Placements		
Mean	.28	.68
SD	.64	.95

Note. All group differences are statistically significant at $p < .01$.

The Bronx was selected as the site for this project because it is a community with many needs. The Bronx is the poorest of New York City's five boroughs, with an average per capita income of $13,266 in 1988 (Rockefeller Institute of Government, 1991). In 1990, its population was 1,203,789, of which 44% are Hispanics and 36% are white. The Bronx has the highest murder arrest rate in New York State (54.3/100,000), representing 25% of all arrests in New York State. The unemployment rate (6.8%) is the highest in New York City. The infant death rate in 1988, at 15.5/1,000 live births, was the highest in the City. And, the Bronx has the second highest dropout rate from public high schools (9.3%) in the State.

Figure 3 summarizes the variations in program attributes among the three models. HBCI+ is an enhanced version of HBCI. In addition to the usual program components, the following are added: two new training components (cultural competence and working with violence in families), a bilingual parent advocate who establishes family support groups and offers individual parent advocacy, the availability of flexible service dollars (on average $100 per family), and the availability of both in-home and out-of-home respite. These additional service components are based on feedback from children's emergency providers.

Crisis case management is somewhat less intensive than HBCI. A crisis case manager will serve four families in crisis and four families requiring generic case management services. Both in-home and out-of-home respite will be available. The service duration will be four to six weeks. Flexible service dollars (on average $150/family) will be available.

Figure 3
A Comparison of Home-Based Crisis Intervention (HBCI), Enhanced Home-Based Crisis Intervention (HBCI+), and Crisis Case Management (CCM)

Program Attribute	Home-Based Crisis Intervention (HBCI)	Enhanced Home-Based Crisis Intervention (HBCI+)	Crisis Case Management (CCM)
Target Population	Children and youth living at home who are at-risk of an inpatient admission due to psychiatric crisis.	Children and youth living at home who are at-risk of an inpatient admission due to psychiatric crisis.	Children and youth living at home who are at-risk of an inpatient admission due to psychiatric crisis.
Program Goal	Resolve immediate crisis, teach skills, improve family relationships, link to needed services.	Similar to HBCI with the added goal of providing long-term family support services.	Assess needs, provide concrete services, link child and family to needed services.
Program Focus	The child within the context of their family.	The child within the context of their family.	The child within the context of their family.
Caseload per Worker	Two families in crisis.	Two families in crisis.	Four families in crisis, four families requiring "generic" case management services. †
Duration of Service	4 - 6 weeks	4 - 6 weeks	4 - 6 weeks
Respite	No respite provided.	In-home and out-of-home respite available.	In-home and out-of-home respite available.
Staff Training	HBCI training.	HBCI training plus training in cultural competence and working with violence in families.	Intensive Case Management and Crisis Intervention training.
Post-Crisis Family Support Services	No post-crisis family support services provided.	Services available through bilingual, bicultural parent advocate who will establish a parent support group and provide individual parent advocacy.	No post-crisis family support services provided.
Flexible Service Dollars	No flexible service dollars are available.	An average of $100 per family is available to meet individualized needs.	An average of $150 per family is available to meet individualized needs.
In-home Visits and Supports	Provided within 24 hours of intake and on a regular and frequent basis throughout the crisis period.	Provided within 24 hours of intake and on a regular and frequent basis throughout the crisis period.	Provided within 24 hours initially, and as needed thereafter.
Psychiatric Services	Psychiatrist available to provide assessment and treatment services within the home.	Psychiatrist available to provide assessment and treatment services within the home.	Psychiatrist consultation available to crisis case managers and to families for medication review.
Funding	State resources only.	State resources for HBCI components and grant funds for enhancements.	State resources for case managers and in-home respite and grant funds for out-of-home respite.

† Families receiving "generic" case management services are not part of this research project.

Revised: 5/17/93.

The primary research questions to be answered are: "What are the differential outcomes associated with the three in-home emergency services? and "Which children and families experience the best outcomes with these options?" The research uses a positive controlled three-group randomized study design, randomly assigning children and families appropriate for

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in-home crisis services to one of the three treatment conditions. The research design and conduct of the research are guided by the research logic model (See Figure 4).

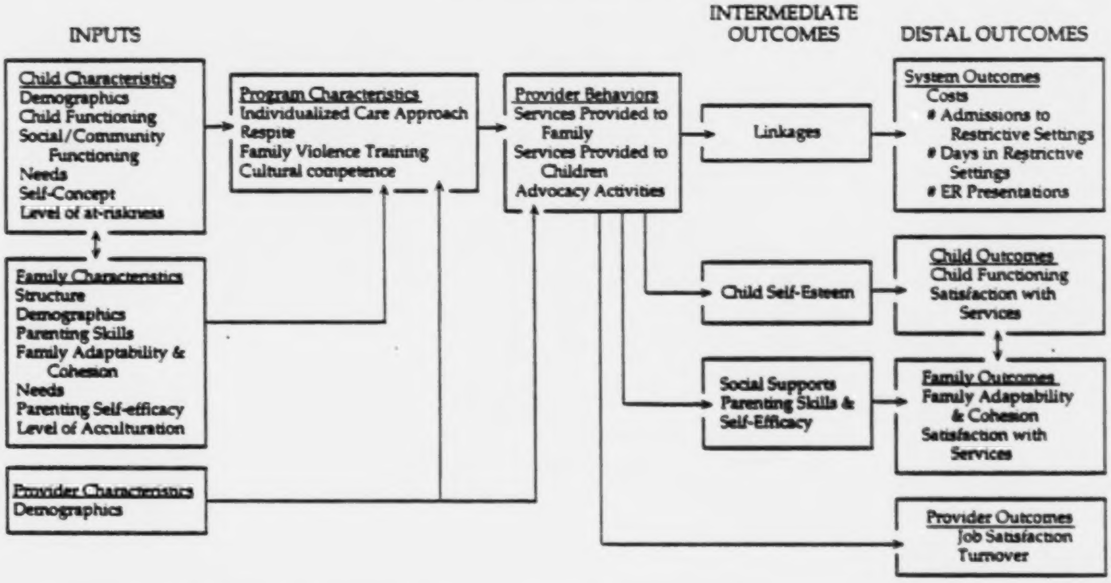
The research logic model identifies nine major domains to be assessed and the hypothesized relationships among these domains. The nine domains include: 1) child characteristics, 2) family characteristics, 3) provider characteristics, 4) program characteristics, 5) provider behaviors, 6) child outcomes, 7) family outcomes, 8) provider outcomes, and 9) system outcomes.

We believe that the system inputs (i.e., child characteristics, family characteristics, provider characteristics) will interact to influence provider behaviors. Provider behaviors, in turn, will result in intermediate outcomes, such as promoting linkages, which will result in the system outcomes. Provider behaviors also lead directly to provider outcomes.

A major strength of this program research initiative is the collaborative relationship with the Hispanic Research Center (HRC) of Fordham University. One of the HRC's tasks is to design and deliver training in multi-cultural competence to staff in the HBCI+ intervention. The training will focus on an awareness and acceptance of cultural differences and how culture impacts the helping process (assessment, diagnosis, engagement, and treatment). The HRC is also responsible for the collection of data from all children and families at program discharge and six months post discharge. To facilitate data collection and ensure data quality among Spanish speaking clients, HRC will hire and train bilingual interviewers.

From June-September, 1993, the two new in-home psychiatric emergency programs (HBCI+ and CCM) will be established in the Bronx where a HBCI program already exists.

Figure 4
Research Logic Model

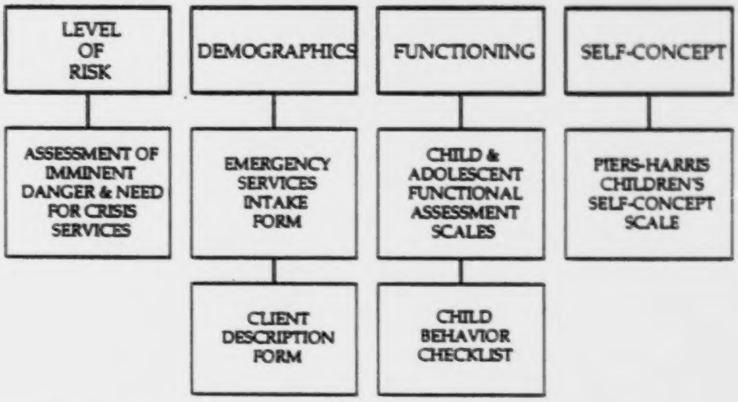

INPUTS
INTERMEDIATE OUTCOMES
DISTAL OUTCOMES
Child Characteristics
Demographics
Child Functioning
Social/Community Functioning
Needs
Self-Concept
Level of at-riskness
Family Characteristics
Structure
Demographics
Parenting Skills
Family Adaptability & Cohesion
Needs
Parenting Self-efficacy
Level of Acculturation
Provider Characteristics
Demographics
Program Characteristics
Individualized Care Approach
Respite
Family Violence Training
Cultural competence
Provider Behaviors
Services Provided to Family
Services Provided to Children
Advocacy Activities
Linkages
Child Self-Esteem
Social Supports
Parenting Skills & Self-Efficacy
System Outcomes
Costs
# Admissions to Restrictive Settings
# Days in Restrictive Settings
# ER Presentations
Child Outcomes
Child Functioning
Satisfaction with Services
Family Outcomes
Family Adaptability & Cohesion
Satisfaction with Services
Provider Outcomes
Job Satisfaction
Turnover

By September 1993, consenting families who present to either of three general hospital psychiatric emergency services and who are assessed as appropriate for in-home crisis services will be randomly assigned to one of the three treatment conditions. Assessments will be made of the characteristics and functioning of the children and families at intake, at discharge, and at six months following discharge. A description follows of the measures used to assess four of the domains in the research model.

Child Characteristics. This domain is comprised of multi-perspective measures of the child's level of risk, demographics, overall functioning, service needs and self-concept (See Figure 5). On presentation to an intake site, an assessment of every child's level of risk and basic demographic characteristics will be completed by a member of the crisis team. This will yield a description of the full population presenting to each intake site and allow for a precise identification of the segment of the psychiatric emergency population served by the study interventions.

For those children assigned to a treatment condition, the Child and Adolescent Functional Assessment Scales (CAFAS) (Hodges, 1990) will be used at intake to assess the child's functioning status from the perspective of the counselors or the crisis case manager (CCM). The CAFAS was developed for use in the Fort Bragg Demonstration Project (Hodges, 1990). Subscales of the instrument measure the child's status in the areas of role performance, thinking, behavior toward other/self, moods, emotions, substance use, and caregiver needs.

Figure 5
Outcomes of Three Children's Psychiatric Emergency Programs
Child Characteristics


LEVEL OF RISK
DEMOGRAPHICS
FUNCTIONING
SELF-CONCEPT
ASSESSMENT OF IMMINENT DANGER & NEED FOR CRISIS SERVICES
EMERGENCY SERVICES INTAKE FORM
CHILD & ADOLESCENT FUNCTIONAL ASSESSMENT SCALES
PIERS-HARRIS CHILDREN'S SELF-CONCEPT SCALE
CLIENT DESCRIPTION FORM
CHILD BEHAVIOR CHECKLIST

Child functioning from the parent's perspective will also be measured at intake by the Child Behavior Checklist (CBCL) (Achenbach, 1991), designed to measure behavioral problems and social competencies of children ages 4-18. The child's perception of their status will be measured by the Piers-Harris Children's Self-Concept Scale (Piers, 1984). Designed to measure the development of children's attitudes about themselves, this self-report instrument will be administered at discharge and at six months post-discharge to all children assigned to treatment conditions.

Child Outcomes. At discharge from the programs, a Discharge Assessment Form will be administered to measure progress in resolving unmet needs listed during assessment and service utilization patterns. Data on admission to restrictive settings and emergency rooms will also be elicited.

At six months post-discharge, child status will be re-assessed by a Six-Month Follow-Up

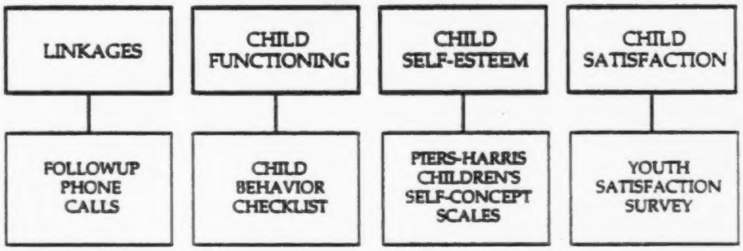
Questionnaire administered by a Hispanic Research Center independent field worker who will interview families at their homes. This interview will assess emergency service utilization, hospitalization patterns, school functioning, contact with mental health and other service systems, tenure in the home, and compliance with service recommendations over the prior six months.

Outcomes for the child will be measured by changes in child self-esteem and functioning, using the CBCL, the CAFAS and Piers-Harris (See Figure 6). These instruments will be administered at six months post-discharge. In addition, the child's satisfaction with services will be measured by a Youth Satisfaction Survey instrument. The Youth Satisfaction Survey is an interview protocol developed and pilot tested by the Bureau of Evaluation and Services Research with input from children receiving ICM services. The interview is designed to assess children's satisfaction with the services they receive. Children are asked questions regarding how they feel about their counselor, what they do when they are with their counselor, what they talk about when they are with their counselor, and about how well they like specific program components such as respite care.

Family Characteristics.

The domain of Family Characteristics is comprised of overall family and parental functioning. Measurement of overall family functioning will be made from the perspectives of the counselor or CCM and the parents using the instruments described below (See Figure 7). In particular, because of the intensive in-family service provided to families in either HBCI conditions, we expect to see that these parents will increase their parenting skills and self-efficacy as compared to parents in families assigned to CCM.

Figure 6
Outcomes of Three Children's Psychiatric Emergency Programs
Child Outcomes



Self-efficacy is defined as self-reported confidence in making and implementing decisions (Bandura, 1986). In this study, emphasis will be placed on increasing the confidence parents have in their ability to provide appropriate parenting for their children. This improvement should have a positive association with preservation of families who have children in crisis. Self-efficacy will be measured using a Parental Self-Efficacy Assessment instrument, to be developed in cooperation with training staff of the Behavioral Sciences Institute, to reflect the core parenting skills included in the Homebuilders training curriculum.

The characteristics and status of the family will be assessed by the Client Description Form and the Supplemental Assessment Form at assignment to a treatment condition. Client Description Form (CDF) was developed by the Bureau of Evaluation and Services Research to establish a minimum data set on a broad array of children's programs. The CDF is used to collect three types of information: a) basic biographic information about the child such as the child's age, race, gender, and current living situation; b) educational information such as the child's special education classification and current educational placement; and c) information on the child's psychiatric history such as diagnosis, symptoms and behaviors displayed within the past 18 months, and prior placements. CDFs have been in use for over three years. For this study additional information on family composition, income, and relationships was desired and will be collected using the Supplemental Assessment Form (SAF). Changes in these areas will be tracked through follow-ups by counselors and CCMs at discharge as well as by other follow-up interviews conducted by field interviewers at discharge and six months post-discharge. Family Functioning will be measured using the Family Adaptability and Cohesion Scales (FACES III) comprised of 20 items, ten adaptability and ten cohesion items (Olson, Portner, & Lavee, 1985).

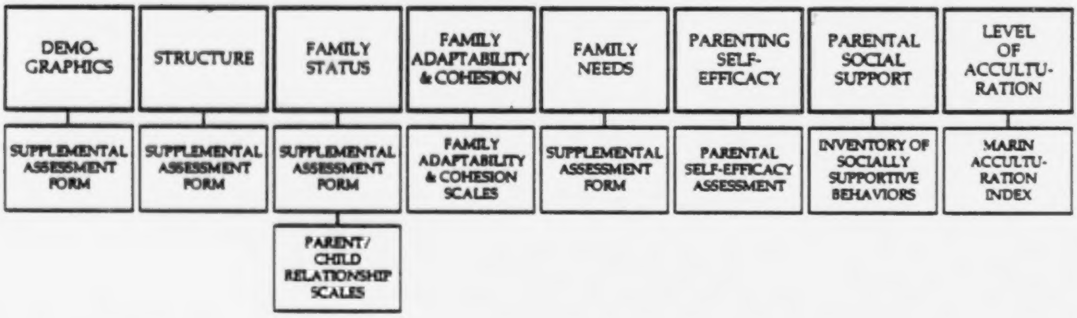
An important enhancement of HBCI+ is the on-going availability of the parent advocate to support families. To measure changes in levels of social support for families, the Inventory of Social Supportive Behaviors (ISSB) (Barrera, Sandler & Ramsey, 1981; Milardo, 1983) will be administered to parents at intake by HBCI counselors and CCMs and at discharge and six months post-discharge by field interviewers. The ISSB contains 40 items and includes instructions that ask for respondents to rate each item's frequency of occurrence (Tardy, 1985).

To test the effectiveness of a culturally competent program on families at differential levels of acculturation, the Marin Acculturation Index (MAI) (Marin, Sabogal, Marin, Otero-Sabogal & Perez-Stable, 1987) will be administered to parents and children at intake to all programs. The MAI has 12 items that comprise three subscales of acculturation.

Parenting skills from the perspective of the counselor and CCM will be measured through six scales selected from the Child Well-Being Scales (CWBS) (Magura and Moses, 1986) that describe interactions between parents and children. These scales are Parental Recognition of Problems, Motivation to Solve Problems, Acceptance/Approval of Children, Consistency of Discipline, and Teaching/Stimulation of Children.

Family Outcomes. These outcomes are measured by changes in parenting skills, parent self-efficacy, family adaptability and cohesion, and perceived social support. Measures

Figure 7
Outcomes of Three Children's
Psychiatric Emergency Program
Family Characteristics


DEMO-GRAPHICS
STRUCTURE
FAMILY STATUS
FAMILY ADAPTABILITY & COHESION
FAMILY NEEDS
PARENTING SELF-EFFICACY
PARENTAL SOCIAL SUPPORT
LEVEL OF ACCULTU-RATION
SUPPLEMENTAL ASSESSMENT FORM
SUPPLEMENTAL ASSESSMENT FORM
SUPPLEMENTAL ASSESSMENT FORM
FAMILY ADAPTABILITY & COHESION SCALES
SUPPLEMENTAL ASSESSMENT FORM
PARENTAL SELF-EFFICACY ASSESSMENT
INVENTORY OF SOCIALLY SUPPORTIVE BEHAVIORS
MARIN ACCULTU-RATION INDEX
PARENT/ CHILD RELATIONSHIP SCALES

described in the Family Characteristics Section (Parent/Child CWBS, Parent Self-Efficacy, FACES, and ISSB) will be used to assess these changes (See Figure 8).

Parent satisfaction with services will also be measured at discharge. This dimension will combine the assessment of the parent's satisfaction with services as well as their view of the cultural sensitivity of their care provider. The instrument is adapted from the Parent Outcome Interview (Magura & Moses, 1986) and the Consumer Rating of Aspects of Culturally Sensitive Service Provision (Johnson, 1990). This measure will be administered by a field interviewer independent from the service provider within one week of discharge from service. At six months, as part of the community follow-up, parents will be asked to respond by mail regarding long term satisfaction with services.

Specific study hypotheses and instrumentation have also been designed for the domains of service system, provider behavior, and program characteristics. We are optimistic that the research project will help us understand better the characteristics and service needs of children and adolescents presenting at psychiatric emergency rooms, as well as what in-home crisis services are most effective with which children and families.

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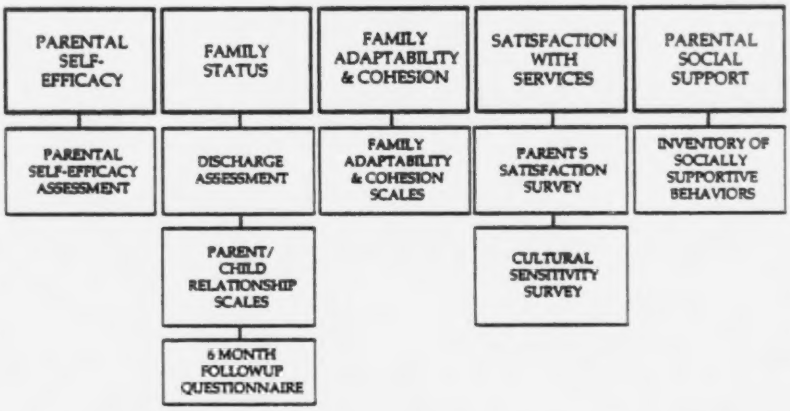
Figure 8
Outcomes of Three Children's Psychiatric Emergency Services Family Outcomes


PARENTAL SELF-EFFICACY
FAMILY STATUS
FAMILY ADAPTABILITY & COHESION
SATISFACTION WITH SERVICES
PARENTAL SOCIAL SUPPORT
PARENTAL SELF-EFFICACY ASSESSMENT
DISCHARGE ASSESSMENT
FAMILY ADAPTABILITY & COHESION SCALES
PARENT'S SATISFACTION SURVEY
INVENTORY OF SOCIALLY SUPPORTIVE BEHAVIORS
PARENT/ CHILD RELATIONSHIP SCALES
CULTURAL SENSITIVITY SURVEY
6 MONTH FOLLOWUP QUESTIONNAIRE

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Family Reconciliation Services: Over A Decade Later

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This paper presents some exploratory data on the characteristics of adolescent children and their families referred to a voluntary, short-term crisis intervention program located in a public child welfare program. The paper also provides some preliminary information on services provided and services needed but not available. While overall the program was successful in providing brief, short-term counseling to families in conflict, the study found a sub-set of families who had long-term chronic problems. Although accepted into the program for services, the chronic nature of the problems experienced by these families makes it unlikely they would respond to a short term crisis intervention program.

Introduction

In July 1991, the Washington State Legislature required that the Department of Social and Health Services conduct an evaluation of the Family Reconciliation Services Program. The Family Reconciliation Services Program (FRS) is a short-term crisis intervention program designed for "status offender" youths. The goal of the FRS program was to reunite, strengthen, and maintain families and prevent out-of-home placements. FRS offered family assessments, community referrals, and in-home family counseling for a time-limited period to alleviate family conflict. If the conflict could not be resolved with the youth in the home, the youth or parent could file an Alternative Residential Placement petition (ARP), requesting the court to grant legal authority for an out-of-home placement. The ARP provided legal structure and penalties for contempts. In response to a need for legal structure in those cases where out-of-home placement was not required, the legislature amended the original FAS law of 1987 in 1990 to provide a second legal vehicle, the Youth at Risk petition (YAR).

The specific questions to be answered in the evaluation were as follows:

1. A description of services offered in Phase I and Phase II of FRS;
2. The number and characteristics of youth and families served by FRS and the outcome of services provided to youth and families;

3. A description of outreach services, including program information, provided to youth and families;
4. The number and type of referrals to FRS from law enforcement, juvenile courts, schools and community agencies and their perception of its effectiveness;
5. Follow-up contact with a random sample of youth and families receiving FRS services and their perception of the effectiveness of these services;
6. The number of youth referred again after services were terminated and outcome of services provided;
7. The number of youth and families who requested specific services but who did not receive services because they were not available; and
8. Recommendations for improving services to at-risk youth and families.

Study Design

The design of the evaluation was such that there were multiple measures and data sources utilized to answer the required legislative questions. In order to conduct a comprehensive review of the program within funding limitations, written material related to the program was reviewed, FRS staff and families were interviewed ($N = 100$), and a public agency case file review was conducted on a random sample of families receiving services ($N = 400$). This evaluation resulted in five interim reports. This paper will focus on a few of the findings related to characteristics, services, outcomes, and families' perceptions of the effectiveness of services provided and services needed but not available.

Findings

In a one-year period, 17,000 families were screened into the FRS Phase I program for up to four hours of crisis intervention. The screening criteria was such that only families assessed as at high risk for placement, or high risk for intra-family violence received services in Phase I. Approximately 1 in 4 ($N = 4,200$) of the families who passed the initial screen were referred for Phase II services. Phase II services included fifteen hours of intensive, in-home counseling, and a family could receive a variety of other services including home builders, home-based services, placement, and/or referral for alternative residential petitions.

Demographic Characteristics

There were slightly more females (54%) than males (46%) referred to the program. Four out of five families were Caucasian, and just over one-half (58%) were two-parent families. One-third (30%) of the families had already had prior agency contacts in the FRS program or in the Child Protective Services program.

Child Problems Identified by Families

One component of the characteristics of families was an examination of "identified problems" by the family and caseworkers. This data was collected from the child's caretaker in the family interview and from case files (See Table 1).

What is most interesting is that when families were asked about the kinds of problems the children exhibited, they identified significantly more problems than were identified in the program assessments. Families were significantly more likely to identify their children as running away and non-compliant, and as having school problems, than were caseworkers. Parents also reported their children as more verbally and emotionally abusive, as well as destructive of property, than caseworkers did. Of concern is the lack of identification of suicidal and mental health problems by caseworkers.

In contrast, the parents of these children had different problems. The mothers in these families were abusive (15%), physically violent (11%), or had a substance abuse problem (10%). Up to five percent of the mothers were suicidal, mentally ill, developmentally disabled, or had criminal histories. The fathers had similar problems, but more of them. One in five (21%) of the fathers were abusive, 17% were physically violent, and 15% had substance abuse problems.

Table 1
Child Problems Identified by Families Compared to Problems Documented in Case Files

Problem	Identified by Family[a]	Documented in Case Files[b]
Non-compliant	85%	69%
Runaway	65%	45%
Sexual Offenses	9%	3%
School Discipline Problems	67%	24%
Truancy	54%	29%
Union/Separation or Divorce	32%	30%
Substance Abuse	27%	22%
Verbal/Emotional Abuse	67%	40%
Physical Violence	42%	60%
Property Destruction	49%	13%
Person Crime	29%	15%
Sexual Identity Issues	2%	1%
Suicide Ideation	33%	19%
Suicide Attempt	17%	9%
Physical Disability	14%	3%
Developmental Disability	21%	3%
Mental Health Problems	27%	15%
Learning Disability	34%	3%
Gang-related Activity	15%	4%
Anger Management	78%	54%
Other	13%	64%

(a) *N* = 100 families participating in phone interview

(b) *N* = 367 families identified in case file review

A Comparison of Identified Child Problems by Agency History

While there are some differences in child problems for children who had prior agency contact compared to those who were first time referrals, there are not as many differences as one might expect (See Table 2). The families who had already been served in the FRS program in the past had children who were more likely to be physically violent and to have exhibited criminal behavior. Children whose families were new to the program were less likely to be suicidal than children who had received agency services in the past.

Services Identified by Families as Wanted But Not Received

Families had no trouble identifying services that they wanted but did not receive (See Table 3). The services most frequently identified as wanted but not received were additional intensive counseling, anger management, and school coordination. In fact, families who were dissatisfied with the services indicated that they did not receive the services they wanted or needed. In other words, they did not want less services, but more.

Reasons for Unavailability of Needed Services

When asked why they did not receive the services they wanted, families indicated three reasons: there was no offer of services or no response from the case worker; they did not know why they did not receive the service; or, the family did not have the resources to obtain or access the service (See Table 4).

Case Outcomes

Table 5 summarizes what happened to the families who were referred for, and received services from, the FRS program:

About 1 in 3 families actually completed the full range of services and/or successfully resolved their conflict. There were a variety of reasons why the remaining families did not complete the services offered. Services were not completed due to the family choosing not to continue because of dissatisfaction with services, the family decided services were not appropriate at that time, resources were not available, the family did not engage in services,

Table 2
A Comparison of Identified Child Problems By Agency History (b)

	Current Episode (N = 367)	Single Referral (N = 188)	Prior FRS Referral (N = 49)	Prior Child Abuse Referral (N = 130)
Noncompliance	70%	67%	82%	68%
Runaway	46%	44%	56%	42%
School Problems	24%	25%	27%	21%
Truancy	29%	33%	35%	18%
Substance Abuse	22%	21%	38%	17%
Emotional Abuse	20%	20%	23%	21%
Physical Violence	31%	28%	44% (.09) [a]	31%
Criminal Acts	36%	16%	29% (.07) [a]	16%
Suicidal Behavior	23%	11% (.07) [a]	19%	20%
Mental Health Problems	9%	8%	15%	9%
Anger Management	31%	29%	42%	29%

[a] The significance level indicates that the variable relationship approaches significance, i.e., the differences do not occur due to chance.

[b] The percentages in each column reflect the number of children in that category who had documented problems.

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or for other reasons. This level of outcome is of some concern given that a variety of families in this study had already received services in this program in the past, or in the more intrusive Child Protective Services program.

One explanation for the level of outcome for this program is that many of the families who were screened appear to have a level of problem severity that would not necessarily be responsive to a short-term crisis intervention. While the services offered in FRS might resolve the immediate crisis, they do little or nothing for the underlying issues that support a family with chronic dysfunction. While the program was developed for short-term crisis intervention for youth who runaway and families in conflict, it became, over a ten-year period, the program of last resort for families with adolescents who have chronic problems. Fur-thermore, it is not just the children who have chronic problems, but the families with prior child abuse and neglect have parents who have chronic long-term problems that require more than a brief crisis intervention approach.

Summary

While the majority of children and families referred to the Family Reconciliation program successfully resolved their problems in Phase I (under 4 hours of crisis intervention), if a family did not resolve their crisis immediately and were referred to Phase II, they were significantly less likely to achieve a "successful" resolution to the problem. Because the focus of the FRS program was brief, short-term crisis intervention, the counselors did not identify, and/or the families did not reveal, the

Table 3
Services Identified by Families As Wanted But Not Received

Anger Management	16%
Phase II (DCFS and Contracted)	23%
Community Counseling	15%
School Coordination	13%
Substance Abuse Treatment/Evaluation	11%
Psychiatric Treatment/Evaluation	10%
Domestic Violence Services	9%
Parenting Classes/Support Groups	11%
Developmental Disabilities Services	8%
Transportation	8%
Education	8%
Family Planning	8%

extent of the family dysfunction. While the majority of families in Phase II were offered the 15 hours of service, families identified a need for longer term services and different services than those offered. The range and depth of problems, and needs of these families, far out-paced the scope of the program. Recommendations regarding review of program operations were made to the agency.

Table 4
Reasons for Unavailability of Needed Services

Service Needed/Unavailable	Not authorized or no response from case worker	Did not know why service was not received	Family had no money or transportation
School Coordination	33%	33%	34%
Community Counseling	44%	28%	22%
Substance Abuse Treatment and/or Evaluation [a]	54%	0%	46%
Parenting Classes and/or Support Groups	31%	38%	31%
Anger Management [b]	45%	30%	20%

[a] Other $N = 6\%$

[b] Other $N = 5\%$

Table 5
Case Outcomes

REASON CASE CLOSED [a]	N	%
Runaway	24	7%
Moved Away	30	8%
Services not Completed [b]	141	40%
Transferred	4	1%
Incarceration	4	1%
ARP/YAR Closed	1	*f
FRS program overloaded – unable to receive request	3	1%
Case Worker unable to reach family after intake call	5	1%
Family would not engage in services	5	1%
Case referred to community service [c]	4	1%
Case Plan Completed [d]	100	27%
Conflict Resolved [e]	28	8%
Case open	5	1%
TOTAL	354	100%

[a] Missing: $N = 13$, 4%.

[b] Services were not completed due to the family choosing not to continue because of dissatisfaction with services; the family deciding services were not appropriate at that time; resources were not available; family would not engage in services; or other reasons.

[c] Substance abuse treatment, counseling, etc.

[d] Phase II hours complete or similar. Per Case Worker.

[e] No further request for services. Per Family.

[f] * = Less than 1%

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A Home Based Mentor Program as an Alternative To Psychiatric Hospitalization For Children and Adolescents: Three and Six Month Outcome Data

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This paper describes a home-based alternative to psychiatric hospitalization for adolescents and children. The program utilizes specially trained individuals (mentors) who work with a multidisciplinary team, including a child psychiatrist, psychologists and social workers. The treatment is carried out in the context of the Mentor home. Although the program may at first appear to be a variation of foster care, we believe that functionally the program is more similar to psychiatric hospitalization.

In this manuscript, we provide an overview of the operational aspects of the program and present three and six month follow-up data on a cohort of children. These outcome data are then compared with that deriving from similar studies involving the psychiatric hospitalization of children and adolescents.

Introduction

Inpatient psychiatric treatment of children is an integral component of the continuity of care for adolescent and children. This treatment modality, however, carries with it potential side effects such as: the artificial environment of a hospital or large group facility can inhibit the learning of new skills and behaviors, and generalization to other settings; contagion effects; negative modeling; limits on the program's ability to individualize care and treatment; and difficulties in trying to design services that can simultaneously meet the widely diverse needs of patients/client and their families. (Schahill, & Riddle, 1990)

The Mentor model of residential treatment described was conceived as an alternative and more natural setting in which to treat children and adolescents whose clinical presentation requires acute treatment out of their own homes. The Mentor Program model is based on the principle that children with emotional disturbances should be treated in as normal an environment as possible, and in a manner which does not alienate them from their families, is non-stigmatizing, is cost effective and maximizes the potential for the child to return to his/her parental home.

This program may at first appear to be a variation of foster care. While there are similarities to specialized foster care, we believe that, functionally, the program is more similar to psychiatric hospitalization. As with psychiatric hospitalization, the goals of the program include short term stabilization, thorough diagnostic assessment, pharmacological intervention when necessary, active case management and intensive psychotherapeutic treatment, involving both the family and the child. (Jemerin, & Philips, 1988; Doherty, Maderson, & Carter, 1987) All of the children and adolescents admitted to the program are either diverted from psychiatric hospitalization or admitted from a psychiatric hospital.

Program Model Overview

Admissions to the Mentor Program can be arranged 24 hours a day upon referral from a hospital emergency room, crisis intervention team, utilization review clinician or other resource. Rapid response is assured. A Mentor clinician completes an intake assessment and arranges placement into a Mentor treatment home within a few hours of referral. Each patient is under the care of a team of mental health professionals, including a child psychiatrist, while residing in the home of a mental health technician, known as a "mentor". Only one patient is placed in a Mentor treatment home at any one time, thereby allowing truly individualized and intensive care. Clinical coordinators are licensed social workers or psychologists who, in combination with the mentors, form the core of the treatment team. Each coordinator directly supervises no more than four mentors depending on the complexity of their patients' needs.

The Mentor treatment home is a structured but natural environment in which to provide comprehensive assessment, crisis stabilization and treatment services. As an integral member of the treatment team, the mentor is responsible for observation and documentation of patient status, behavioral management, life skills training, therapeutic activities and support and supervision of the patient. The team of professionals is responsible for assessment and diagnosis, treatment planning, comprehensive case management, individual and family therapy, crisis intervention and psychopharmacological services. Twenty-four hour per day back-up to each home is also provided.

The Mentor Program, with an average length of stay of under 30 days, combines the following critical elements of effective psychiatric treatment.

- *Orientation and training:* Comprehensive orientation and education regarding all aspects of the program is provided for referral organizations, including utilization review and case management staff.
- *Crisis intervention:* Skilled clinicians provide timely intervention into the crisis situation.
- *Assessment:* A multi-disciplinary team, under the medical direction of a psychiatrist, provides comprehensive evaluation and diagnostic services.
- *Stabilization:* Acute situations are effectively stabilized through active support, supervision, and structure within a Mentor treatment home.
- *Brief treatment:* Short-term, goal oriented treatment for the individual and family focuses on resolution of the specific problems which precipitated the crisis.
- *Active case management:* Clinicians call upon the full therapeutic impact of community resources and the patient's natural support systems.
- *Utilization review:* Each case is frequently reviewed by a multi-disciplinary team under the direction of a psychiatrist.
- *Discharge planning:* Successful long-term outcome is maximized through careful discharge planning.
- *Reintegration:* The integrity of the family unit is preserved by facilitating a successful transition back home at the earliest appropriate time. As indicated, Mentor can provide in-home follow-up services to minimize the possibility of recidivism.

Referral and Admission Process

Most patients are referred to Mentor Clinical Care by either a psychiatrist, a mental health case manager at a health maintenance organization or an insurance company, and other mental health professionals in the community. At times, patients or family members may contact Mentor directly.

Referral procedures are as follows:

1. The referral agent evaluates the patient and determines that the patient can benefit from a Mentor treatment program.
2. The referral agent reviews the Mentor Program with the patient and, if needed, the patient's family, then obtains approval to make a referral.
3. The referral agent contacts the admission coordinator for the Mentor Intensive Home-Based Psychiatric Treatment Program.
4. An immediate telephone screening interview takes place to determine the presenting problem, preliminary diagnosis, psychiatric or substance abuse history.
5. A Clinical Coordinator reviews the information, consults as necessary with the Medical Director, evaluates the patient regarding appropriateness of admission and begins the process of matching the patient to the most appropriate mentor home.
6. The clinical coordinator arranges an on-site intake evaluation interview typically within 24 hours of the initial telephone referral. The clinical coordinator, the mentor, the referral agent, the patient, and the patient's family may be participants in this interview.
7. The admission can be completed at conclusion of this meeting. All releases and other necessary chart documents are completed and signed. The patient and, if necessary, the patient's family proceed to the mentor home and begin a Mentor treatment program. The primary functions of the admission process are to:

- Develop an accurate assessment of the patient's treatment needs in a timely manner.
- Inform, educate and assist the family in a difficult and stressful situation.
- Complete all arrangements for the patient's admission when residential care is required.
- Provide the initial clinical information to the clinical coordinator and attending psychiatrist who will be treating the patient and working with the family.

Admission and on-going treatment in the Mentor Clinical Care program are on a fully voluntary basis. Normally admissions occur during the hours when Mentor's admission coordinator is available - between 8:30 a. m. and 5:30 p.m. Monday through Friday. After hours there is a clinical staff person on-call to evaluate a potential admission.

Admission Criteria

Mentor's Acute Psychiatric Program is geared for the following child and adolescent patients:

- between 3 1/2 to 21 years of age
- have serious to severe symptoms of a psychiatric disorder, based upon DSM III-R criteria
- have serious to severe impairments in attending to age appropriate responsibilities in one or more major life skills functional areas, as a result of the psychiatric disorder
- manifest significantly impaired judgment and/or thought processes
- require frequent professional intervention and high and consistent levels of structure, supervision and behavior management on a twenty-four hour per day basis

- are not in need of emergency inpatient psychiatric treatment due to acute danger to self or others
- are medically stable, and not in need of intensive nursing services and/or detoxification from alcohol or other chemical substances

The Mentor model has demonstrated success with treating patients with dual diagnoses, including those who in addition to their emotional problems, have a diagnosis of substance abuse, developmental disability, traumatic brain injury, etc. Mentor's continuum of specialized programs allows it to place a patient in the most appropriate program model, and access clinical expertise with a specific disorder or disability from its other program models. This ensures the ability to provide comprehensive treatment for dually diagnosed patients

Costs

The Mentor Clinical Care Acute Psychiatric Treatment Program is capable of producing substantial cost savings as a clinically effective alternative to inpatient treatment for children and adolescents. Mentor's per diem cost is inclusive of all charges and can save 40 to 60 percent of the typical charges for inpatient psychiatric treatment.

Daily Operations

It is difficult to convey the fast paced day to day operation of this program. The time constraints placed on the program are similar to those for psychiatric hospitalization – yet the operational logistics of this program are much more complex. Typically, clinical coordinators will visit each mentor home twice a week for individual sessions with the client and for supervision of the mentor. In addition, an effort is made to have twice weekly family therapy sessions. During the later stages of treatment the client's parents are frequently invited to the mentor home to observe the interactions and behavioral techniques developed by the mentor. A weekly meeting brings all of the members of the interdisciplinary team together to track the progress of the patient and modify the treatment plan. The child psychiatrist is available to evaluate new admissions and to follow-up with those clients requiring pharmacological intervention.

Family Involvement in Treatment

Central to Mentor's program is our ability to involve the family in a direct and positive way, including active involvement in the treatment planning process. While the family may need a period of "respite" from disruptive behaviors, the child or adolescent will ultimately need to be reintegrated into the family. To this end, Mentor seeks to establish a bridge between the mentor home and the family from the very beginning. Mentors provide valuable training, when necessary, to family members in a setting that directly models their own home. Additionally, family members are expected to participate in regular, intensive family therapy facilitated by their clinical coordinator.

Follow-up Data

In order to assess the effectiveness of the program, extensive data are collected at discharge and at three month intervals post discharge. In comparing this program to psychiatric hospitalization, we reviewed the literature concerning diagnostic categories of children and adolescents admitted to psychiatric inpatient units. The diagnostic groupings for the Mentor Program are compared to those data in Table 1.

In this report we will describe the results of a follow-up study assessing treatment outcome at discharge, three months, and six months post discharge. The study cohort include ,at six months, 89 children who were either admitted from a psychiatric hospital (28.7%) or were diverted from an emergency psychiatric hospitalization (71.3%). The average length of stay was 17.9 days. The average age was 12.8 years; 8% were under six, 33.3% were age six to 12 and 57.5% were age 13 to 18. Only one child (1.1%) was over age 18. In this study cohort, 60.9% were male and 39.1% were female.

Table 1
Comparison Of Diagnostic Categories

	Turner et al. 86 *N* = 100	Pyne et al. '85 *N* = 69	Mentor STRT *N* = 112	Blinder et al. '78 *N* = 106	Shafli et al. (15) '79 *N* = 145	King & Pittman '69 *N* = 60	Mans-heim '90 *N* = 34
Disorders	A	C & A	C & A	C	C	A	P
Disruptive Behavior	22%	49%	48%	20%	36%	—	62%
Mood	18%		30%		—	35%	—
Anxiety			16%		—	2%	6%
Personality	7%		4%	19%		15%	—
Sexual	—		1%				
Psychotic	18%	19%	1%	8%	10%	10%	
Adjustment	13%			26%	5%		
Neurotic	7%		—	9%	16%	7%	
Developmental	4%		—	20%			
Psychophysiological	10%			5%	17%	5%	
Neurological With Behavioral Effects	2%	7%		10%		20%	
Mental Retardation				2%	6%	—	—
Other	1%	—				6%	5%

*A = Adolescents C = Children P = Preschooler

**Not all percentage =100 due to rounding off to nearest percentage

The discharge data for the study group indicates that 96.4% of discharges were planned, while 3.6% were unplanned; 72.3% returned home to a biological family or relative; 15.7% were discharged to a less restrictive setting, such as foster care or a group home. 4.8% were discharged to a comparably intensive setting, such as a residential treatment center. The remaining 7.2% were discharged to a more restrictive setting such as an inpatient psychiatric unit. There were no discharges due to unauthorized absences or runaways, despite the unlocked home-based nature of the program.

Both the three month and six month follow-up data were obtained by a structured telephone interview implemented by a masters level clinician who was blind to the actual cases. At six month follow-up 48.4% were living with their parents, a relative, a family friend or an adoptive home. Only 6.7% were residing in inpatient psychiatric units. 13.5% were in residential treatment and 31.4% were in other less restrictive settings such as foster care and group homes. Within the six months, 14.6% had been psychiatrically hospitalized (average number of episodes 1.5 and average length of stay 34.9 days). 59.6% had received outpatient treatment during the six month follow-up period. 4.5% had received day treatment. 19.1% had received foster care or specialized foster care. 15.7% had received residential treatment. 10.8% of the follow-up group were attending public schools and 13.5% were attending a residential or inpatient based school program.

In order to assess the correlates of difference outcomes, the data were analyzed with regard to the patient characteristics of age, sex, admission source, documented history of sexual abuse, utilization of post-discharge outpatient services, and diagnostic category. Of these, only the following factors had a significant impact on outcome: history of abuse, post discharge outpatient treatment, and psychiatric diagnosis. The data for the three month follow-up study are presented in Table 2 and the six month data are presented in Table 3. In order to assess the relative effectiveness of this program as compared to psychiatric inpatient care, we reviewed the published outcome and follow-up data concerning psychiatric hospitalization of children and adolescents. The

Table 2
3 Month Follow-Up Data (*N* = 61)

Respondent's Relation to Patient	# clients	percentage
Self	7	11.5%
Birth Parent	46	75.4%
Adoptive Parent	1	1.6%
Public Agency Case Manager	5	8.2%
Other	2	3.3%

Living at Time of Follow-Up Interview	# clients	percentage
Not Specified	1	1.6%
Birth Family Home	39	63.9%
Home of Relative	2	3.3%
Psychiatric Hospital	3	4.9%
Substance Abuse Treatment Facility	1	1.6%
Residential Treatment Facility	3	4.9%
Foster Care	7	11.5%
Specialized Foster Care	3	4.9%
Other	2	3.4%

Participation in Mainstream School/Job	# clients	percentage
Not Specified	3	4.9%
Attending Regularly	45	73.8%
Attending Periodically	1	1.6%
Capable, but Unwilling to Attend	7	11.5%
Not Yet School Age	2	3.3%
Attending Hospital/Residential School	3	4.9%

Post-Discharge Community Services	# clients	percentage
Outpatient Services	40	65.6%
Day Treatment Services	1	1.6%
Foster Care	11	18.0%
Specialized Foster Care	1	1.6%
Residential Treatment	9	14.8%

Post-Discharge Inpatient Psychiatric Services	# clients	percentage
# Patients Hospitalized	5	8.2%
Avg. Bed Days/Hospitalized Patient		21.8%

three month Mentor follow-up data are compared to the comparable psychiatric hospitalization data in Table 4.

Stake-holders, HMOs, Third Party Payers and Other Professionals

The recent crisis in the health care industry has forced private payers to look at ways to reduce or maintain levels of spending. They are aggressively attempting to put together a continuum of care which includes cost effective alternatives to inpatient care.

Because of the status of the industry, the usual resistance one would expect given any new program model has diminished considerably. Many private payers are willing to consider purchasing these services. We were impressed with their emphasis on securing competitively priced services with a high standard of quality. They were particularly concerned regarding safety issues, not only because of liability concerns, but also as a quality of care issue. One of the major mechanisms we use in overcoming the understandable reluctance about using a new program is the rigorous quality assurance and clinical follow-up work which is conducted on an ongoing basis. In attempting to find comparable data for psychiatric hospitalization of children and adolescents, we were surprised at the relative paucity of studies in this area despite the billion dollar size of the industry.

Table 3
Six Month Follow-Up Data
(*N* = 89)

	Residence at Time of Follow-Up			% Psychiatrically Hospitalized Within Follow-up Period	Regular Attendance at School	
	Home	Less Restricted	More Restricted		Public	Residential
Age:						
12 & under (41.3%)	47.3%	31.6%	21.1%	15.8%	84.2%	5.3%
13 & over (58.7%)	49.1	31.3	19.6	13.7		60.8
Female (39.1%)	60.1	22.8	17.1	17.1	65.7	14.3
Male (60.9%)	40.8	37.0	22.2	13.0	74.1	13.0
Admission Source:						
Diversion (71.3%)	49.1	33.3	17.6	14.0	75.4	105.0
Step Down (28.7%)	52.0	19.2	28.0	16.0	60.0	20.0
Substantiated Physical or Sexual Abuse:						
Abused (12.4%)	9.1	45.4	45.5	36.4	63.6	27.3
Nonabused (87.6%)	56.6	28.4	15.0	15.1	67.9	11.3
Outpatient Treatment Post-Discharge:						
Yes (59.6%)	56.6	37.7	5.7	9.4	83.0	1.9
No (40.4%)	36.2	22.1	41.7	22.2	52.8	30.6
Major Diagnostic Categories:						
Behavioral Disorder (44.9%)	32.5	41.0	27.5	17.5	72.5	17.5
Mood Disorder (24.7%)	40.9	31.8	27.3	13.6	59.1	22.7
Anxiety Disorder (12.4%)	72.7	27.3	0.0	18.2	81.8	0.0

These follow-up studies have been useful in neutralizing concerns about a new program not only because of the results, but also due to the commitment to clinical excellence that is inherent in this demanding quality assurance program.

Mentor Clinical Care considers families to be major stake-holders. Whatever their level of functioning they are pivotal in the treatment of their children. Families clearly are not as invested in cost issues. Quality of care, clinical excellence, and safety weigh heavily for them. They need assurance that Mentor Clinical Care is the optimum level of treatment for their child. Because most families are in crisis prior to their child's admission, the family physician or

Table 4
Comparison of Discharge and Follow-Up Data

	N	Age Range	Discharge Disposition	Recidivisim	Follow-Up
Mentor Short term residential	61	3-21 yrs	72% family or relative 17% less intensive (foster care) 5% comparative 6% more restrictive	5 admitted to psychiatric hospital during follow-up period	67.2% family or relative 4.9% specialized foster care 11.5% foster care 16.4% other
Blinder, et al.	130	3-13 yrs	72% Home 5% Foster Home 6% Group Home 7% Residential 1% Death	7 Readmitted during 2 year course of study	Discharge & readmit data only
Turner, et al.	100	Adolescents	69 Home 10 Part home 21 Not home	Not Stated	6 month follow-up 47 Home 13 Part home 19 Not home 21 unknown
Davis, et al.	74	14-19 yrs	Not Stated	Not Stated	1 year follow-up 84% Home 40% At school 37% Employed 29% Psych. Residence 62% Psych. residence since discharge
Shafil, et al.	145	2-16 yrs	82% Home or prev. res. 16.5% Placed out of home 1.5% Long term state facility	7.5% (11) readmitted during course of study	Discharge & readmit data only
Pyne, et al.	70	Adolescents	42 Planned discharges 17 Unplanned child-parent 11 Expelled	Not Stated	

a professional must play the role of advisor to help the family make the appropriate decision regarding treatment for their child.

The physician or professional then has considerable influence regarding utilization of the Mentor Clinical Care Program. We have found that this group shows the private payers concerns: particularly regarding quality of care, safety and liability. The sophisticated Quality Assurance and clinical follow-up systems certainly appeared to alleviate many of these concerns. It has been Mentor Clinical Care's experience that once a physician or professional makes his/her first referral, they will becoming on-going advocates of the program.

Finally, we can address the client. We have not found clients necessarily difficult to persuade (except for the normal adolescent opposition). Many children/adolescents have been institutionalized prior to referral to us and prefer the less stigmatized Mentor model. Additionally, as we are aware, many of our clients have little real choice and are dependent on their family and the professional community to choose the right level of care for them.

In summary, the crisis in the health care industry has given Mentor Clinical Care an opportunity to demonstrate the efficacy of this level of care. Our adherence to delivering high quality clinically effective services to children/adolescents and their families has allowed our program to be considered as a credible, fundable standard of psychiatric care.

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Preliminary Outcomes for Children with Serious Emotional Disturbance in Two Community-Based Service Programs

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The New York State Office of Mental Health is conducting a research demonstration project (1R18MH48072/5HD5SM48072) to assess the comparative effectiveness of therapeutic foster care and intensive supportive care within the natural home environment. This study uses a positive controlled randomized study design with repeated measures and randomly assigns children with serious emotional disturbance (SED) appropriate for therapeutic foster care to either family-based treatment (FBT, a treatment foster care program) or to family-centered intensive case management (FCICM). Assessments are made at enrollment, 6, 12, and 18 months and 6 months post-discharge to determine the child, family, and system outcomes of these interventions.

To date, 25 children with SED and their families have been receiving service in FBT and FCICM. This paper overviews the program models and discusses the characteristics and functioning of study participants on enrollment and at 6 month follow-up. Data on services provided and use of flexible service dollars are also presented.

Introduction

Significant changes are occurring in the mental health system serving children with serious emotional disturbance (SED) and their families. The array of services has moved beyond hospitalization and clinics to include several models of intensive community based care. Most of these models are in their infancy and they have not been systematically evaluated. In October 1990, the New York State Office of Mental Health's (OMH) Bureaus of Children and Families and Evaluation and Services Research received funding from the National Institute of Mental Health, now funded by the Center for Mental Health Services, to study the outcomes of two such programs.

The project has two specific aims. The first is to establish a new program model, Family Centered Intensive Case Management (FCICM), in three rural New York State (NYS) counties. The second is to compare FCICM's outcomes with those of Family Based Treatment, NYS's model of treatment foster care, established in the same counties. Figure 1 compares the salient aspects of the program models.

Figure 1
Program Models

PROGRAM ATTRIBUTE	FAMILY BASED TREATMENT	FAMILY-CENTERED INTENSIVE CASE MANAGEMENT
TARGET POPULATION	CHILDREN WITH SED	CHILDREN WITH SED
PROGRAM GOAL	MAINTAIN CHILD IN FAMILY-LIKE SETTING	MAINTAIN CHILD WITH FAMILY
PROGRAM FOCUS	CHILD WITH SED IN FOSTER FAMILY	CHILD WITH SED & FAMILY
CASELOAD	5 FOSTER & 2 RESPITE FAMILIES	8 NATURAL & 2 RESPITE FAMILIES
STAFFING	FAMILY SPECIALIST	FAMILY-CENTERED INTENSIVE CASE MANAGER
CRISIS RESPONSE CAPABILITY	24 HOURS/DAY; 7 DAYS/WEEK	24 HOURS/DAY; 7 DAYS/WEEK
ADVOCACY	TARGETS INDIVIDUAL CHILD	TARGETS INDIVIDUAL CHILD & SYSTEM OF CARE
PARENT SUPPORT	FOR FOSTER PARENTS	FOR NATURAL PARENTS
RESPITE	FOR FOSTER PARENTS	FOR NATURAL PARENTS
FLEXIBLE SERVICE DOLLARS/ SUBSISTENCE ALLOWANCE	$500/CHILD/YEAR	$2,000/CHILD/YEAR

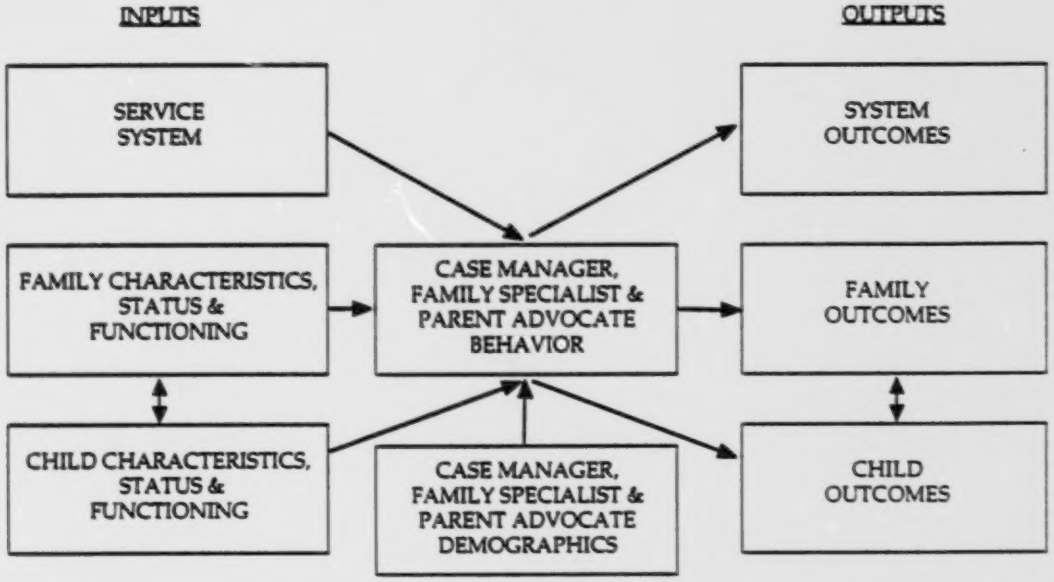
The logic model in Figure 2 shows the domains of interest. The outcomes include system, family and child outcomes.

Research Methods

Children with SED 6-12 years of age who are referred to FBT are randomly assigned to either FBT or FCICM. Assessment of symptoms and functioning are made on admission and at 6 month intervals, including 6 months post discharge. The Child Behavior Check List (CBCL) (Achenbach, 1991), Child and Adolescent Functional Assessment Scales (CAFAS) (Hodges, 1990), and Piers-Harris Children's Self-Concept Scale (Piers, 1984) are used for this assessment. Similar levels of functioning are expected on termination from both of these treatment conditions.

Family assessments are also done upon admission and yearly. The Family Adaptability and Cohesion Scales (Olson, Portner & Lavee, 1985) are completed by all family members 12 years of age and older. The CBCL is completed on all siblings over 4 years of age. Piers-Harris are completed on all siblings over 8 years.

Figure 2
Logic Model for the Research


INPUTS
OUTPUTS
SERVICE SYSTEM
SYSTEM OUTCOMES
FAMILY CHARACTERISTICS, STATUS & FUNCTIONING
CASE MANAGER, FAMILY SPECIALIST & PARENT ADVOCATE BEHAVIOR
FAMILY OUTCOMES
CHILD CHARACTERISTICS, STATUS & FUNCTIONING
CASE MANAGER, FAMILY SPECIALIST & PARENT ADVOCATE DEMOGRAPHICS
CHILD OUTCOMES

Because of the intensive in-home supports offered to biological families in FCICM, it is hypothesized that sibling functioning will be superior in the FCICM condition.

Service system assessments are focused on the number and types of services available and their perceived adequacy as rated by persons knowledgeable about the system. The Assessing the System of Care for Children with Serious Emotional Disturbance (New York State Office of Mental Health, 1990) is administered in years one and three using a snowball sampling technique. Cost data and data on services provided by child care workers are collected in all three years.

To date, 32 children have been enrolled. Enrollments have been slower than expected due to fiscal problems and concern about random assignment to treatment condition. It is also interesting to note that once enrolled, children are remaining in these treatment conditions longer than the 12 months expected.

Description of Enrolled Children

Baseline data are available on 28 children, 11 in FBT and 17 in FCICM. Descriptive data on the children show no statistically significant differences between those assigned to the two conditions. Figure 3 gives an overview of the characteristics of children enrolled in the study. Figure 4 shows that children have impairments in all four areas measured by the CAFAS, but have greater impairments in role performance, moods/emotions and behavior.

Enrolled children fall into the clinical range on the CBCL Total Problem ($\bar{X} = 74$), Internalizing ($\bar{X} = 68$), and Externalizing ($\bar{X} = 75$) scales.

Figure 3
Child Characteristics
(N = 28)

AGE AT ADMISSION	Mean = 8.0 years
RACE/ETHNICITY	82% White non-Hispanic
SEX	Male (93%)
CUSTODY	Biological/Adoptive Parents (82%)
EDUCATIONAL PLACEMENT	Special Education (57%)
PRIMARY DIAGNOSIS	Disruptive Behavior D/O (78%)
FAMILY DISRUPTIONS	Mean = 1.3
BEHAVIORAL PROBLEMS & SYMPTOMS (e.g. temper tantrums, anxiety)	Mean = 6.9
AREAS OF FUNCTIONAL IMPAIRMENT (e.g. self-direction, social relationships)	Mean = 2.3
COMMITTEE ON SPECIAL EDUCATION CLASSIFICATION	Emotionally Disturbed (56%)
CHILD BEHAVIOR CHECKLIST Total Problem Score	Mean = 74

There are no significant between group differences. On the syndrome scales of the CBCL, enrolled children are in the clinical range of the Anxious/Depressed, Delinquent Behavior and Aggressive Behavior scales. Total Competence score shows that 70% fall into the clinical range.

Description of Enrolled Families

Figure 5 shows the characteristics of 24 of the enrolled families as assessed by the professional child care worker. Poverty or unstable income was the problem cited most often (75% of families) as interfering with treatment. Assessment of 20 of the 24 enrolled families on whom we had data at the time of this presentation (n = 38 parents and older siblings) using the Family Adaptability and Cohesion Scales, showed that only 13% of families fell into the extreme range.

Professional child care workers were asked to assess family strengths by indicating whether the family has the ability or willingness to provide eight types of support for the child. These were comprised of understanding the problem, implementing a treatment plan, calling the treatment team when needed, transporting the child, identifying the need for respite, providing structure, using appropriate punishment, and making the child feel loved. The family strengths identified most often, in about 68% of families, were calling the treatment team and identifying the need for respite. Only about 30% of families were able to transport the child to needed services.

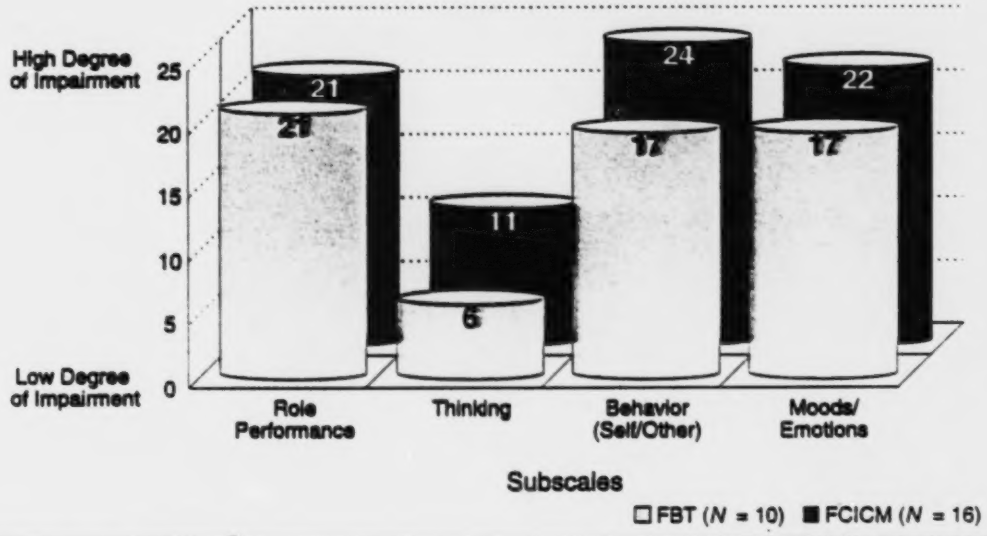


Figure 4
Child and Adolescent Functional Assessment Scales Mean Scores

Figure 5
Family Characteristics

CHARACTERISTIC	PERCENT OF FAMILIES (N = 24)
HOUSEHOLD COMPOSITION	83% have 2 adults
POVERTY	75%
UNSTABLE RELATIONSHIPS	58%
MENTAL ILLNESS	46%
CHRONIC UNEMPLOYMENT	46%
DOMESTIC VIOLENCE	31%
ADULTS ABUSED AS CHILDREN	29%
ALCOHOL/ SUBSTANCE ABUSE	21%

Service Utilization and Unmet Needs

A majority of children in the FCICM intervention (9 of 14) and almost half in the FBT intervention (5 of 11) used respite Respite was used slightly more often in FBT (30 vs. 24 times), but the average number of days per episode was higher in FCICM (5.3 vs. 4.0 days).

The goals of these treatment programs include keeping children in the least restrictive setting appropriate to their needs and minimizing emergency room contacts. Although it is too early to assess the effectiveness of treatment programs in this regard, we noted that 3 children enrolled in FCICM and 1 in FBT visited emergency rooms for psychiatric services during their first 6 months in the program. Also there were 4 admissions of children served by FCICM to state psychiatric centers with a mean length of stay of 9.9 days (range 5-76 days) and 1 admission of a child from FBT who stayed 98 days.

In keeping with the differences in program models, flexible service money was used differently in the two treatment programs. The majority of money in FBT was spent on meeting basic needs (49%) or for treatment aids (28%), while in FCICM the money was distributed across home improvement (26%), recreation (24%), basic needs (21%), and transportation (20%).

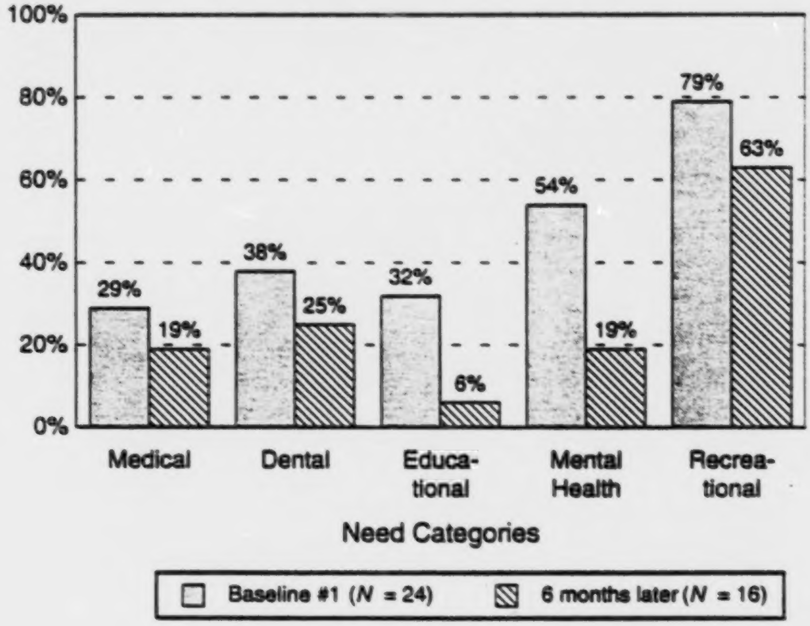
Finally, Figure 6 shows the percent of children receiving services since admission and the percent with unmet needs in the areas of clinic services, training in activities of daily living, and medication management. Children in both conditions have shown important decreases in unmet needs..

Conclusion

This project is now in its third year and has been enrolling children and families for 19 months. On the basis on the information presented here, we believe that we have enrolled the right children and families, i.e., children with SED who are being referred for out-of-home placement. The random assignment process, although difficult to implement and maintain, has been effective in that, to date, there are no significant differences in the characteristics or functioning of children assigned to the two treatment conditions.

Children in both groups have experienced symptom reduction, although at 6 month follow-

Figure 6
Percent of Children with Unmet Needs



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up this has not yet reached the level of statistical significance. Symptom and functional improvements in children with SED typically take some time to occur. Our enrollees are staying in the intervention longer than the 12 months we anticipated, and, hopefully over time, will begin to show a continued decline in unmet needs and a significant improvement in functioning.

We have been learning a lot about the natural history of these two interventions as the study has progressed, however, in order to test the study's hypotheses, we will need additional time to follow children into their post-treatment phase. To allow us to do this we have applied for funding through a two year competitive renewal from the Center For Mental Health Services.

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Qualitative Evaluation Of Community Based Prevention Services: The Monmouth County 65K Program

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Background

The Monmouth County 65K project had a unique origin. It was *established in response to a service consumer*. A mother, who was a human services professional working in Monmouth County, had a son who was placed in a residential treatment center. It was her belief, if sufficient community supports were provided, that she successfully could bring her son home a year prior to his scheduled release from residential treatment. Other local professionals supported her in this belief, and the Department of Human Services was approached. The proposal was, if her son could be successfully brought home a year early from residential treatment, that the State would give a grant of $50,000 (the amount which would have been spent on the second year of residential treatment) to the Mental Health Association of Monmouth County. Monmouth County matched this grant with $15,000, earmarked for purchase of services from the Institute for Educational Programs (IEP), an agency which provides therapy and respite care.

Program Description

The 65K Project, named for the amount of the grant awarded, was to serve six children: three from DYFS and three from the mental health system (having been admitted to either UNDMJ or some other psychiatric hospital), all of whom would otherwise be placed in residential care.

The goals of the program are to:

> ***Prevent the residential placement of seriously emotionally disturbed (SED) youth by providing an array of services within the community to the youth and his family. These services will support an individualized case plan and will vary in both type and intensity of service depending on the needs of the family.*** (Program Description for Wrap-Around Services Program, pg. 1)

There were few program eligibility requirements other than those stated above. One important restriction was that the child, to be eligible for program services, had to have a committed parent or caretaker in the community willing to offer him or her a home. This was the only actual programmatic restriction.

Intake began in January of 1991, and participants were selected from those being reviewed by the Monmouth County Residential Review Committee, the predecessor to the CART. By May of 1991, six children and their families were enrolled in the program. At this point, funds were not being expended as quickly as anticipated, and the project staff decided to expand services to two more children and their families. The last child was enrolled in August 1991. Six of the eight cases were still actively enrolled in the program as of August, 1992.

Process Evaluation of the Program

The program is unique in its implementation, in that the focus of all intervention is centered in the unique team which is developed for each family served. Although some individuals serve more than one team, others do not. The following are some of the program's unique characteristics, which distinguish it from other services offered to this population of New Jersey consumers:

- A unique team is established for each family.
- Individualized treatment is given to each family.
- There is a consistent team membership for each family.
- The team meets monthly to review and reassess the family's case plan.
- The team serves as both planner and service provider. The team acts as the treatment team for the family. Minutes of team meetings perform the role of a "case record" for the family.
- Children are invited to team meetings, especially when there will be decisions concerning them, unless the therapist recommends against it.
- Paid case managers take responsibility for coordinating implementation.
- Team meetings and Project interventions have a family wide focus. Services are extended to parents and siblings.

Lessons Learned During Implementation

As implementation proceeded, the 65K Project teams learned from both program successes and failures. The following are examples of the lessons learned:

- Initial meetings tended to include as many as ten representatives, whereas later meetings were often as small as five participants.
- At the outset, team meetings regularly lasted two hours or longer, but more recently, there has been an attempt to limit them to one hour.
- During the early months of the project's operation, funds were not expended to pay case managers for each case. In the absence of paid case managers, there were instances in which implementation of family plans did not occur. At present, several families have case managers paid from Project funds who are responsible for program implementation and coordination of team efforts.
- Whereas initially, the Project was operating below its funding level, case

expenditures increased steadily. An expansion of the service population from six to eight families, which seemed feasible based on expenditures during the early months, was the precursor for a deficit of funds later. At that point (December 1991), expenditures had to be curtailed for budgetary reasons.

Methodology

Background

The evaluation of the program began in the Spring of 1991, with some important initial parameters of the evaluation already in place. The initial evaluation plan included the provision that it would be important to keep track of the program's shadow budget: the in-kind contributions of individuals and agencies to service delivery efforts. The importance of this aspect of the project came from the fact that community resources could be voluntarily acquired for this small project which would not be forthcoming should the project be expanded. It was considered important to obtain an accurate estimate of program costs to avoid underbudgeting at a later point. While community groups and organizations might be willing to subsidize some innovative services for six or eight children, they would not be able to do so for the one hundred plus children currently receiving residential treatment services countywide.

Initially it was hoped that a control group of children not selected for the program could be followed along with the experimental group. This did not prove to be feasible, as both programmatic and evaluation resources were limited, and as there was no motivating factor built into the project to maintain participation by control group families.

The absence of a control group is one of the weaknesses of this evaluation. A second weakness is the small size of the sample of children and families who were served. Thus, this study and its findings must be viewed as exploratory and impressionistic in nature.

Another shortcoming of this evaluation is the fact that, since six of the eight cases are still active, it is not possible at this point to determine whether or not these families will be able to maintain their child in the community in the absence of the program's supportive services. A follow up study is therefore recommended in one year's time to track the outcomes of these cases after their termination from the program.

Data Collection

Data for the evaluation were collected in several ways. To obtain a clear picture of the process of program implementation and the evolution of program procedures, a series of interviews was conducted with key personnel. Perceptions and attitudes of key actors were also obtained during this process.

The major data collection effort was to review the "case records" (team meeting minutes) for each family. The case record review covered a one year period, from 3/1/91-3/1/92. Data for all eight families were collected by Ann Gans of the Mental Health Association on characteristics of the families, problems experienced by the families, services received, and case outcomes. Problems were measured using a time series design with four measurements: referral data; intake data; case handling data; and follow up data. Services were measured at two points in time: service delivery and follow up.

A detailed self-administered questionnaire was distributed to the parents/caretakers of each of the eight children. The survey instruments were delivered to the parents in person by project staff, and parents were provided with a stamped addressed envelope to mail the instruments directly to BREQA. In this manner, anonymity was assured to the families. Seven of the eight parents completed and returned the questionnaire. This instrument asked parents to report and evaluate the services they had received. They were asked to measure the extent of problems experienced by their families at the point of intake and at the point of follow up. Parents also were given the opportunity to comment on team operations and on the role which parents should play in team meetings.

A brief self-administered questionnaire was distributed to agency representatives who served as team members to obtain their input. The same method of distribution and collection was utilized for this survey. Of approximately thirty agency representatives who received the survey, fourteen returned it. Most respondents provided thoughtful narrative responses to the open ended questions included in this survey which provided valuable data regarding implementation issues faced by the project.

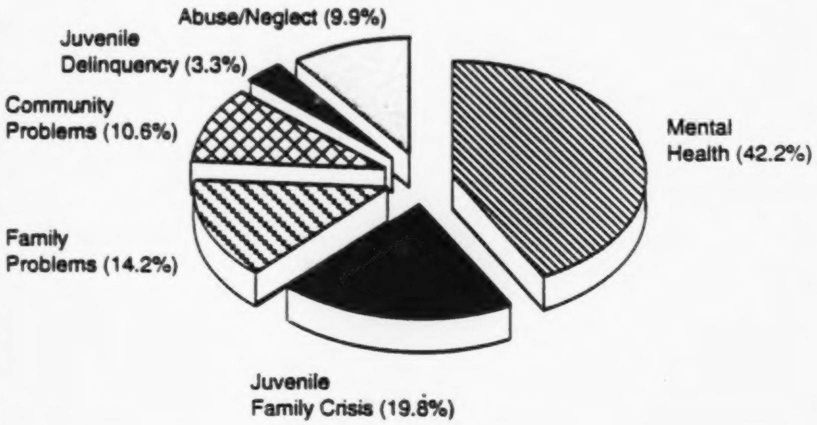
Detailed financial information was submitted by the Mental Health Association on cash expenditures. These data were supplemented with estimates of in-kind costs, including: dollar value of the time expended by team members in attending team meetings; time spent in travel to and from team meetings; and hours spent by DYFS workers who supervised cases involved in the project. By obtaining data on this "shadow budget", it was possible to make a more accurate estimate of the true costs involved in administering the program.

Findings

Problems Identified

The average number of distinct problems identified for a typical family was 38. Since the program required that three of the children served be selected from the mental health system, it is not surprising that 42.4% of the problems identified were mental health problems. Juvenile Family Crisis problems (19.8%) and other Family Problems (14.2%) were also frequently identified. Community problems, including school problems, was the next most frequent category of problems noted (10.6%). Abuse and Neglect accounted for only 9.9% of the problems identified. Figure 1 depicts the distribution of problems within a typical family.

Figure 1
Problems Experienced by Families in the 65K Program



Patterns of Intervention

The pattern of intervention utilized in this project is quite different from that traditionally employed. The level of intervention is much more intense, and the types of services offered are unique to the individual family. There are, however, some patterns which exist. Recreation and socialization services are offered to the child in almost every case, and are frequently offered to the parent as well. This is done in a community based context with the intent of keeping the family mainstreamed, and of avoiding the stigma of "separate" services. Individual and family therapy are also offered frequently. Services address the health of the child and availability of neighborhood resources. Where appropriate, there is intervention with the school system. The data were combined to determine the percentage of areas in which various levels of intervention occurred. There was documented intervention in 70% of the family life areas studied during the evaluation, with services purchased in 29%, referral and advocacy in 23%, and discussion only occurring in 19%.

Parents' Perceptions

The Parent Questionnaire gathered parents' assessments of program intervention in twenty-two areas. The survey was distributed to all eight families who had participated in the program, and responses were received from seven of these families. The parents were relatively satisfied with the services they had received. Average ratings ranged from "excellent" to "OK", with a mean and modal response of "good" in all areas except one, the "other category". In this area, only one parent gave a rating, and the rating given was "poor". This parent identified an area of concern as limited resources available for wraparound services at certain points in time, explaining her rating by saying "only because it seems their hands are tied at the present time and help or relief is not available... the wraparound services provide wonderful help for those in need when they have the much needed funding and serious commitment of volunteers and paid staff members."

Parents also indicated that their teams had been very thorough in discussing all of their concerns at team meetings, that the teams had actually inquired into additional areas as well, and that they had received services in 51% of the areas discussed in the survey. This agreed nicely with the 52% figure for areas in which

Figure 2
Services Offered to Children

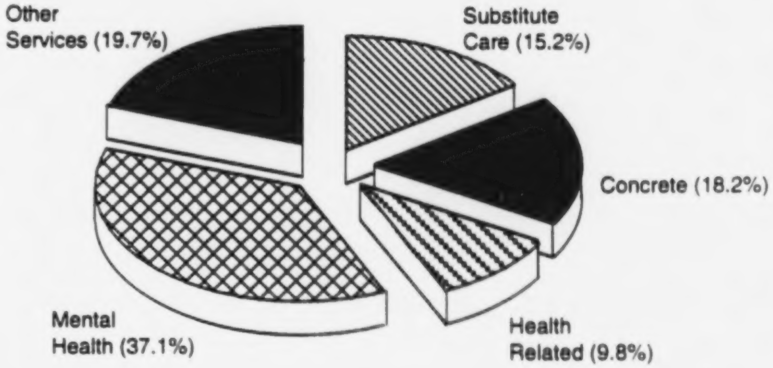
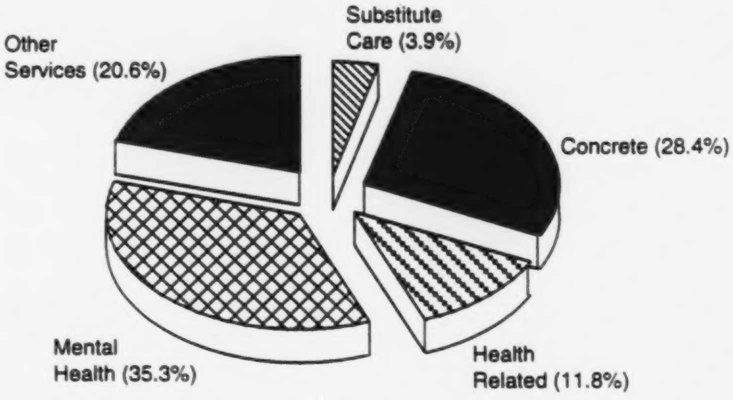


Figure 3
Services Offered to Parents



parents had initially perceived that problems existed. They had learned of new resources in 44% of the areas, an indication of the development of an actual or potential safety net of resources for future needs. When parents were asked to indicate the areas in which problem resolution had occurred, they indicated that they had experienced problem resolution in 57% of the areas in which problems had initially existed. This agrees fairly well with the data obtained from a review of team meeting minutes, discussed above. Parents unanimously responded that service provision in their cases had been enhanced by the actions of the team.

Agency Perceptions of the Program

A survey of agency representatives who had served on at least one family's team indicated that they also had an enthusiastic view of the program and its effectiveness. Agency respondents praised the operation of the teams, and indicated the importance of the role played by parents on the team. The majority did feel that the parent should only be present for a portion of the team meeting time. Like the parents, they almost unanimously felt that service provision for the families had been enhanced by the actions of the team.

Services Provided

The "typical" child enrolled in the program received sixteen or seventeen different services: a Youth Advocate (YAP) worker, respite care, hospitalization, recreation and socialization, education related services including advocacy and tutoring, substance abuse services (if required), protective services, crisis intervention, psychiatric evaluations, individual and family therapy, and case management (See Figure 2).

The "typical" parent received twelve or thirteen different services: information and referral services, a parent advocate, inpatient health services, protective services, crisis intervention, recreation and socialization, individual therapy, family therapy, self help groups, food, and other concrete services (See Figure 3).

Problem Resolution

Follow up data were gathered from team meeting minutes for each family as of March 1, 1992, at which point six of the eight families initially enrolled were still receiving services from the project. The percentage of problems for which resolution (21%) or partial resolution (44%) had occurred at the time of follow up totaled 65%. This finding is particularly encouraging in view of the fact that 3/4 of the cases were still actively receiving services at the time of the follow up measurement (See Figure 4).

Some types of problems were more likely to be resolved than others. Community problems, including those arising at school, were most likely to be resolved. At follow up, 75% of these problems were either totally (50%) or partially (25%) resolved. Juvenile family crisis and other family problems were also frequently resolved or partially resolved, with only 20%-24% remaining unresolved. Mental health problems were rarely totally resolved (6%), but were partially resolved 50% of the time. A similar profile applies to abuse and neglect problems, which were never totally resolved, but which were partially resolved 50% of the time. The project appears to have had little success in addressing problems in the area of juvenile delinquency.

By the time of follow up, the typical family had totally or mostly resolved eight separate problems. There had been partial problem resolution in an additional sixteen areas. Problems still persisted in fourteen areas. Although an attempt was made to create a profile of the specific problems in each category, the degree of variation from case to case precluded doing so in any meaningful way.

Analysis of the Shadow Budget

If only cash expenditures are considered, the project appears to be very cost effective. In actuality, however, 37% of the resources utilized in the project were contributed in kind. Time spent at team meetings by staff of various agencies was the largest in kind category, followed by the extra time invested by case managers in the Division of Youth and Family Services. Although agency participants in this small pilot project were able to give time for team meetings without additional compensation, it is unlikely that a similar in kind contribution could be sustained in a larger project. Consequently, in an expansion of this or similar projects, it is imperative that additional staff time to participate in team meetings and additional service activities be budgeted into project costs at the outset.

Conclusions

Perhaps the most effective method of assessing program performance is to measure a program in terms of its stated goals and objectives. The 65K Program had several such objectives. As previously stated in the Program Description section, the overall objective was to:

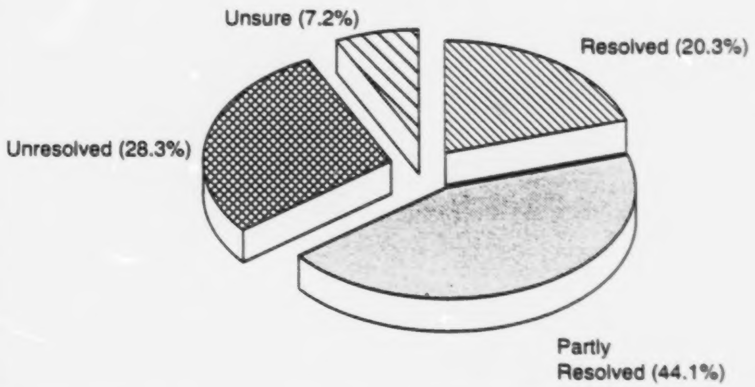
> *prevent the residential placement of seriously emotionally disturbed (SED) youth by providing an array of services within the community to the youth and his family. These services will support an individualized case plan and will vary in both type and intensity of service depending on the needs of the family.* (Program Description for Wrap-Around Services Program, pg. 1)

The children enrolled in the 65K Program appear to meet the definition of serious emotional disturbance to which the program's goal refers. Five of the eight children had experienced psychiatric hospitalization prior to referral, while a sixth child was residing in a psychiatric hospital at the time of referral. An average of twenty separate problems, ten of which were mental health problems, were recorded in the Team Meeting records of the children reviewed. The second portion of the objective relates to prevention of residential placement of these children, and to development and implementation of a plan of services. Of the eight children enrolled in the program during its first year of operation, six remained in the community at the end of the data collection period. One had been placed in residential treatment, and the remaining child had been placed in a group home (a less restrictive setting than that originally planned for the child). A unique Treatment Team was established for each family, and the Teams met on a monthly basis or more frequently throughout the review period. Service plans for the family were developed during Team Meetings and implemented by the Team, frequently under the leadership of a case manager paid by project funds.

A series of five specific objectives spelled out the program's intended outcomes more fully, and each of these will be quoted and discussed separately.

> *The first goal is to maintain SED children in the community by providing an extensive and comprehensive array of*

Figure 4
Percentage of Problems Resolved for 65K Program Families



> *services to the children and their families, and thus prevent residential placement. While traditional social service systems focus and serve the SED child, the need to support and strengthen the family is frequently not addressed adequately. This program seeks to enable the family to maintain the SED child in the home by providing services and supports to other family members as well.* (Program Description for Wrap-Around Services Program, pgs. 3-4)

An examination of the types of services provided to families and children enrolled in the program was completed to determine whether this objective had been met. Children enrolled in the program received an average of 16.5 different services, while their parents/caretakers received an average of 12.75 different services. Services were also provided for siblings and other family members.

> *The second goal is to develop a comprehensive and individualized service plan for each child and family in the program. Services will include: case management, an array of clinical services, in- and out-of-home respite, recreation, substance abuse services, vocational assessment and training, independent living, and transportation to services.* (Program Description for Wrap-Around Services Program, pgs. 3-4)

An individualized service plan was developed and implemented for each child, as indicated in the objective. Case management, clinical services, in- and out-of-home respite, recreation, and transportation were key components of these plans. The importance of case management was underscored during the evolution of the program, as the project began to pay for this service. Both parents and agency representatives commented on the importance of a committed and skillful case manager to make the program really work. Substance abuse services and vocational assessment and training were utilized in some families, particularly in working with the parents/caretakers. Since the children enrolled in the program were relatively young, with an average age of thirteen, these services were infrequently addressed to the children. Independent living was not utilized in any of the cases.

> *The third goal is to create a system in which multiple agencies can collaborate to provide coordinated and integrated services for children and their families through use of a flexible payment system which will allow for more rapid access to services.* (Program Description for Wrap-Around Services Program, pgs. 3-4)

The average team size initially was approximately ten members, and the duration of Team Meetings was approximately two hours. The team size decreased to approximately five members as the project evolved, and the average duration of Team Meetings was decreased to one hour. Approximately thirty agency representatives served on these eight teams, and fourteen of them responded to the agency survey distributed to all Team Members. Several respondents commented positively on the level of collaboration, coordination, and service integration achieved by the project. Others commented on the benefits of the flexible payment system utilized to allow more rapid service access.

> *The fourth goal is to serve as a research model to analyze the benefits to the children and their families as well as how agencies collaborated and cost savings. If successful, the program can serve as a model for expansion and replication through the State.* (Program Description for Wrap-Around Services Program, pgs. 3-4)

The project has provided a wealth of qualitative data on the children and families served, the evolution and growth of project operations, the services provided, the resources utilized, the program outcomes in terms of both prevention of residential placement and resolution of family problems, and the perceptions and attitudes of parents and agency members who served on Treatment Teams. Project outcomes certainly justify implementation of the program on a broader scale.

It is recommended that a controlled experiment be implemented in Monmouth County in which a minimum of thirty randomly selected children and their families would be selected from those reviewed by the Monmouth County CART. To adequately measure the outcomes for these children and families, they should be compared to a control group of at least thirty children selected randomly from the same pool of children and families. Resources should be provided to the Mental Health Association to provide services to the thirty experimental children, and to track the problems, services, and outcomes experienced by both this group and the control group. Control group families should receive remuneration for their involvement in the data collection process. The two groups should be measured at referral, during service delivery, and for a period of one year following their termination from the program to determine outcomes for both the experimental and control groups. The data collection instruments developed in this project can be utilized, with minor modifications, to track the progress of the experimental and control groups. A principle investigator would also be required to revise the data collection instruments, and to analyze the data collected.

> *The fifth goal is to estimate the total cost of caring for SED children within the community environs and utilizing local social service agencies and supports. A ledger of in-kind services will be maintained.* (Program Description for Wrap-Around Services Program, pgs. 3-4)

An accurate and detailed record of expenditures of both cash and in kind resources utilized by the project has been maintained, as proposed. The financial data indicates that the project is cost effective. At an average early cost of $19,399.43 per child for twelve months of service ($12,153.25 in cash and $7,246.18 in kind), the project expenditures average 41.8% of the cost of residential treatment services. This figure, however, does not tell the complete story. Of the eight children, two were placed out of home during the project year. One child was placed during the last month of the data collection period in Orchard House Group Home, at a cost of $120/day, or $3,360.00 total. A second was placed for over six months at Mount St. Joseph's, a residential treatment center, at a cost of $19,791.14. If these costs are added to the other costs of the project, the total expenditures for these children then amount to $146,014.22, or an average of $22,293.32 per child. Assuming that each of the eight children would have been placed in residential treatment at the statewide average cost of $46,421 in the absence of such a program as 65K, the cost of care for these children would have been $371,368.00 for the year, a savings of $193,021.44, or $24,127.68 per child. At this rate, the project would continue to be cost effective if it were to divert half of the children served. In actuality, as of the end of the project year, project success was 75%. Also, it is the opinion of the DYFS expert responsible for residential placement decisions in the county that the one child who was placed in residential treatment would, in the absence of project services, have been placed in a much more costly and restrictive setting, namely Wiley House, an out of state residential facility.

Symposium

Family Preservation Using Multisystemic Treatment with Adolescent Offenders and Substance Abusers: Long-Term Outcome, Current Projects, and Interagency Collaboration

Chair

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The purpose of this symposium was to present findings, updates, and pertinent issues regarding several controlled clinical trials evaluating the effectiveness of family preservation using multisystemic treatment (MST) with adolescent substance abuse and serious criminal behavior. As such, the first presentation described key aspects of MST as used within the family preservation model of service delivery. Second, 2-year follow-up data from the highly successful Simpsonville Family Preservation Project were presented. The third presentation examined findings from the Missouri Delinquency Project, which represents the most comprehensive and extensive evaluation of MST to date. The fourth presentation described progress in a NIDA-funded project evaluating the effectiveness of multisystemic family preservation services with substance-abusing delinquents. The fifth presentation provided preliminary results regarding a NIMH-funded evaluation of the diffusion of family preservation using multisystemic therapy with serious juvenile offenders in rural sites. Finally, key issues in the development of interagency collaboration were discussed, as such collaboration is essential to the success of family preservation projects.

Clinical Overview of Multisystemic Family Preservation Services

Scott W. Henggeler

The purpose of this symposium was to present findings, updates, and pertinent issues regarding several controlled clinical trials evaluating the effectiveness of family preservation using multisystemic treatment with adolescent substance abuse and serious criminal behavior. As such, the first presentation described key aspects of multisystemic therapy (MST) as used within the family preservation model of service delivery. MST is a pragmatic, problem-focused treatment that targets interventions directly at key correlates of delinquency and substance abuse (e.g., parental rejection, low parental monitoring, association with deviant peers, poor school performance). In family preservation, a range of services is provided youths and families in their natural environment, caseloads are low, treatment is time-limited, and services are intensive.

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The Simpsonville Multisystemic Family Preservation Project with Serious Juvenile Offenders: A 2.4-Year Follow-Up

Sonja K. Schoenwald

The Simpsonville Project was a controlled clinical trial funded by CASSP, and findings at an approximately 1-year follow-up were recently published. These findings showed that family preservation using multisystemic therapy (MST) was effective at reducing rates of criminal behavior and incarceration in a sample of 84 deep-end juvenile offenders.

This presentation described results from a 2-year follow-up of the youths who participated in the Simpsonville Project. Archival records were searched for re-arrest an average of 2.4 years post-referral. Survival analysis was used to depict differences in re-arrest between youths in the family preservation versus usual services conditions. This analysis showed that youths who received multisystemic family preservation were less likely to be re-arrested than were youths who had received usual services.

Such results represent the first controlled demonstration that family preservation, when delivered via a clearly specified treatment model, has lasting positive effects with serious juvenile offenders. The findings suggest that MST may successfully interrupt the criminal careers established by serious offenders by mid-adolescence. This possibility is particularly encouraging, given that serious antisocial behavior has been shown to be highly stable (i.e., is highly correlated with adult criminal behavior).

The Missouri Delinquency Project

Charles M. Borduin

Findings were presented from the Missouri Delinquency Project, which represents the most comprehensive and extensive evaluation of multisystemic therapy (MST) to date. Two hundred chronic juvenile offenders, who averaged 4.2 arrests, were randomly assigned to MST vs. individual therapy conditions. Pretreatment and posttreatment assessments, which included self-report and observational measures, were used to assess individual, peer, and family functioning from multiple perspectives, and recidivism data were collected 4 years following treatment. Observational data showed that, relative to families in the individual therapy condition, families that received MST evidenced more supportiveness and less conflict-hostility in mother-adolescent, father-adolescent, and mother-father relations; families that received MST also reported more cohesion and adaptability. In addition, adolescents who received MST had significantly fewer behavior problems following treatment, and their parents reported less symptomatology. Each of these changes is consistent with identified correlates of delinquency. Analyses of the 4-year follow-up data revealed that recidivism rates were 22% vs. 71% for therapy completers (42% vs. 72% for premature terminators) in the MST and individual therapy conditions, respectively. Moreover, recidivists in the MST condition were arrested less often and were arrested for less serious crimes than were recidivists in the individual therapy condition. Thus, MST was more effective than individual therapy in preventing criminal behavior (i.e., rearrests) and also in reducing the number and seriousness of crimes among those youths who were rearrested.

Multisystemic Family Preservation with Substance Abusing Delinquents

Susan Pickrel

Adolescent substance abuse has serious personal and familial consequences. When paired with criminal offending, its consequences extend to detrimental effects on victims, their families, and the larger community. These serious consequences argue for the development of treatments that will effectively target both adolescent substance abuse and delinquency. Yet, few studies have demonstrated the effectiveness of any particular treatment of delinquency or of substance abuse.

A growing body of empirical evidence indicates that delinquency and adolescent substance abuse both are multiply determined. Potentially effective treatments should recognize and address these determinants. One such treatment is multisystemic therapy (MST), a highly individualized family- and home-based therapy grounded on a social-ecological model of development. Because MST has demonstrated efficacy in treating a variety of serious adolescent and family problems, it holds promise in the treatment of adolescent substance abuse.

In Charleston, SC, family preservation using MST is being tested in a randomized controlled trial supported by the National Institute on Drug Abuse. One hundred and twelve 13- to 16-year-old adolescents who have both a substance abuse problem and delinquency are randomly assigned either to receive usual services (e.g., outpatient treatment at the substance abuse commission) or MST. Family preservation using MST involves 3-4 months of intensive family-based treatment that addresses family, peer, school, and individual problems. Pretreatment, posttreatment, and follow-up (6-month and 12-month) assessment batteries include self-report measures, observational measures, and drug screens to evaluate individual, family, peer, and school functioning. Following the completion of treatment, participants in MST will be randomly assigned to receive continued therapeutic monitoring with possible booster sessions or to receive no continued monitoring. This experimental manipulation will help to determine whether continued monitoring promotes the long-term maintenance of therapeutic gains.

To date, of 46 enrolled cases, 20 have completed pre- and post-treatment assessments. Preliminary comparison of usual services and MST groups indicates more gains in abstinence from substance abuse and delinquency and deceased institutionalization in the MST group. This is reflected in decreased self-reported substance use in the MST group, while self-reported substance use in the usual services group increased, and a larger decrease in self-reported delinquency, and fewer rearrests and out-of-home placements in the MST group.

Diffusion of Multisystemic Family Preservation Services with Serious Juvenile Offenders

Michael J. Brondino

The Family Preservation Diffusion Project is supported by a CMHS research grant awarded to the South Carolina Department of Mental Health. The project provides multisystemic family preservation services (MFP) to severe and/or chronic juvenile offenders and their families. The goals of the project are: 1) to demonstrate, using a true experimental design, the effectiveness of MFP services in reducing criminal behavior and out-of-home placements, 2) to track the diffusion of information about the project into the professional community, and 3) to demonstrate the cost effectiveness of MFP services as compared to services currently provided families of serious juvenile offenders.

Services are provided by state mental health professionals in three majority rural African-American counties and three urban and rural majority Caucasian counties. Over the course of the project, a targeted sample of 204 youth and their families will be assigned to receive MFP services or the usual services of the juvenile justice system (DJJ). Measures assessing the impact of treatment on the juveniles, families, peer groups, and school performance are being administered at pretreatment, posttreatment and six-month follow-up.

Pretest and posttest data on the first 54 youth and their mother figures is currently available. The youth in this subsample ranged in age from 11.7 to 17.3 years (*M* = 15.12 years), 44 were male and 10 female, 78% were African-American and 22% Caucasian. Mother figures' ages ranged from 25.5 to 75.5 years (*M* = 41.39). In over 77% of the cases, these women were the single head of the household. Mother figures' highest levels of education ranged from 3-18 years (*md* = 10.5). Only 46.3% of the mother figures and 31.6% of the adolescents of legal age were employed. Approximately 73% of the adolescents had been placed out of the home at least once prior to the pretest measure. The youth reported having committed an average of 13.5 total offenses over the 4 months prior to the pretest measure, 29.6% had committed a felony assault, 63.1% felony theft, and 63.3% a crime against a person.

Mother figures in the MFP condition reported significant decreases in socialized-aggressive problem behavior for their adolescents, and experienced fewer symptoms of psychological distress (depression, obsessive-compulsiveness, somatic complaints, and excessive interpersonal sensitivity) following treatment than their control condition counterparts. MFP mother figures reported improved family cooperation in accomplishing family tasks, while MFP adolescents and DJJ mother figures reported less cooperation with family task accomplishment. MFP mother figures at posttest reported more confidence than DJJ mother figures that their adolescent was not going places he or she shouldn't and is less swayed by friends into going or doing things he or she shouldn't. The results indicate that MFP provided by mental health professionals is achieving its goal of empowering parents to direct and regulate events in their family and decreasing youth antisocial behavior.

Crisis Family Preservation vs. Hospitalization of Youths with SED

Melisa D. Rowland

The central goal of this study is to determine whether an intensive family- and home-based treatment (i.e., Crisis Family Preservation) is a more effective and less costly strategy than psychiatric hospitalization for addressing the mental health emergencies of adolescents with SED. Thus, this study directly addresses the widely held concern that children's mental health services have overrelied on expensive and restrictive inpatient treatments (e.g., Burns & Friedman, 1990; Office of Technology Assessment, 1986, 1991; Saxe, Cross, & Silverman, 1988; Stroul & Friedman, 1986). Furthermore, the proposed study builds directly on the accomplishments of CASSP supported research and the Public-Academic Liaison initiative on formulating mental health policy and services in the state of South Carolina.

Specifically, this study includes a 2 (treatment condition: Crisis Family Preservation vs. hospitalization for crisis stabilization) x 4 (time of assessment: 2 weeks postreferral, posttreatment, 6- and 12-month follow-ups) design, with random assignment to treatment conditions. Participants will include 168 12- to 17-year-old adolescents with SED referred to the project by the Crisis Stabilization program of the Charleston-Dorchester Community Mental Health Center. Youths will be presenting severe mental health problems such as homicidal intent, suicidal intent, serious affective disorder, or psychosis. A comprehensive multimethod, multisource evaluation of therapeutic effectiveness will address the following questions:

1. To what extent does Crisis Family Preservation services prevent hospitalization and reduce the symptoms precipitating the crisis?"
2. "Over the long-term (i.e., 12 months), to what extent does Crisis Family Preservation maintain reductions in identified symptoms; ameliorate the family, peer, and community problems associated with such symptoms; and prevent subsequent institutional placement?"
3. "What factors moderate or mediate therapeutic outcome?"
4. "What are the comparative financial costs of the treatment conditions?"

Establishing Interagency Relations

David G. Scherer

Each of our family preservation projects has endeavored to develop favorable interagency relations, and such relations have contributed to the positive results described in the aforementioned studies. Our assumption is that research and service-delivery resources are maximized by interagency endeavors that pool the complementary strengths of agency institutions. Effective interagency collaboration requires *structures that work*, *process facilitation*, and *negotiation of values*. Strategies for maintaining these principles in interagency collaboration were discussed in the context of the Family Preservation Diffusion Project.

Structures that work: An important structural issue is the establishment and respect for agency *boundaries*. Agencies have procedures and policies that collaborating institutions need to respect. A second issue pertains to the defined *roles* of each participating agency and to fulfillment of such roles. Problems arise when agencies compete for or abdicate responsibility. A third issue regards the distribution of *power*, with conflict likely to arise around issues of control, autonomy, and authority. Agencies providing financial support may demand accountability and decision-making authority. Similarly, agencies providing services and research participants may insist on control over accessibility to participants and treatment protocols.

Process facilitation: Facilitating interagency process requires constant *attention* and the capacity to repair trouble spots. A sense of *trust*, reliance, and dependability needs to be established between collaborating agencies. Moreover, the collaborating organizations must learn to *communicate* effectively, which is often complicated by differences in language, values, and priorities.

Negotiation of values: Establishing effective collaboration requires a willingness to negotiate values. Each agency will bring their distinctive priorities to interagency projects. Fulfilling these priorities and finding the appropriate compromises relies on strong leadership and the efforts of specifically designated project staff. Interagency coordinators and advisory boards are instrumental in achieving these goals.

The Role of Education in Systems of Care

Chapter 4

Interagency Collaboration Through A School-Based Wraparound Approach: A Systems Analysis Summary of Project WRAP

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The WrapAround Project (WRAP) is a school-based interagency collaboration model which recently completed an eighteen-month systems planning process funded by the U.S. Department of Education. Components of the system improvement model which emerged through the planning process include a school inclusion process, an interagency referral and case coordination structure, development of non-categorical wraparound supports for children and families, a local and state parent advocacy network and an interagency focus on reallocation of resources to promote wraparound service delivery. This paper summarizes the process and results of the eighteen-month systems planning project which included the initiation of wraparound to youth and families on a pilot basis. A particular focus on the needs of families and schools is included.

Introduction

In October, 1991, the La Grange Area Department of Special Education (LADSE) was awarded a grant from the U.S. Department of Education to conduct an eighteen month systems planning process to create an effective system of support and education for youth with emotional and behavioral disabilities (EBD) and their families. The focus of LADSE's WrapAround Project (WRAP) has been to develop and pilot a system design based on the wraparound approach. This approach involves "wrapping" supports and services around youth and their families in natural environments. The primary focus of Phase I of Project WRAP was to evaluate and assess the existing interagency system while piloting new approaches for providing services in school, home and community settings. A systems improvement plan has been developed for Phase II implementation. Project WRAP's Phase II plan was one of the projects subsequently selected for implementation by the U.S. Department of Education for 1993-95. In addition, the Illinois State Board of Education (ISBE) began funding a school inclusion component, Wraparound in Schools (WAIS) for a three-year implementation beginning July 1993.

Overview

Phase I activities involved the delivery and coordination of wraparound services to 15 targeted youth with EBD and their families. An interagency Coordinating Council was involved in the creation of wraparound supports for these targeted cases, and provided specific needs assessment information for the design of Phase II. Student and family outcomes, cost effectiveness and systems improvement data collected during Phase I resulted in the proposed systems improvement plan.

Phase I of WRAP has laid the foundation for a successful systems change process by creating a cohesive interagency network and initiating more normalized supports to students and families. Mental health services have been integrated into schools. Students have been returned from residential placement and others have been successfully deflected from placement. Strategies and outcomes emerging from this planning process have led to the development of an interagency referral and case coordination network which was initiated in September, 1992. The expansion of these wraparound efforts to ensure the schools' readiness and capability to effectively educate these students is a critical component. Implementation of a school inclusion model during Phase II will allow more comprehensive application of wraparound strategies inside schools.

The comprehensive needs assessment and process of constituency building during Phase I has resulted in the development of an interagency service network and case coordination system which utilize existing resources more productively. This emerging structure involves redirection of state and local resources across educational, mental health and other agencies to provide wraparound services for youth and families in their homes, schools and communities. Other innovative aspects of the WRAP systems design which emerged during Phase I include parents as case managers for their own families, in-school respite supports to facilitate inclusion, mental health services integrated into schools, school-wide peer support programs, parent advocacy partners and a decreased reliance on categorically designed services. A national, state and local parent network and an interagency coordinating council are also important components of the plan. Finally, influencing state level collaboration around funding, regulations and incentives for inclusive community-based services is a critical focus.

Phase II of WRAP involves moving from planning activities and pilot efforts to full implementation of a comprehensive systems change plan. This process coordinates and integrates existing resources into an effective and normalized service system for students with EBD and their families. The transition from a planning stage to a systems improvement process will impact greater numbers of children/youth and families as the focus of the existing service delivery system is restructured. The Phase II design is based on the types of strategies found to have broad impact and result in effective systems of care (Boyd, 1992; Nelson & Pearson, 1991; Stroul & Friedman, 1986). These include: a) comprehensive planning and needs assessment; b) modifying existing systems; c) interagency collaboration; d) technical assistance and training; e) constituency building; and f) local system development. The WRAP Project's system plan is based on models which Boyd (1992) describes as catalysts for directing inter-systems linkages and collaboration. Table 1 illustrates how WRAP activities/components correlate with model system components identified in the literature.

Phase I Systems Needs Assessment Summary

Phase I of Project WRAP's systems planning project focused on analyzing the existing system through a comprehensive needs assessment process. The following section describes a multi-level process which includes data collection from hands-on experience with providing wraparound to a target population, questionnaires and surveys, and on-going interagency collaboration activities.

The goals of the needs assessment process included:

- assessment of the existing community service system
- evaluation of the overall functioning and adequacy of the existing service system
- identification of service needs as defined by both consumers and providers
- comparison and evaluation of the different priorities of parents of youth with EBD, and school, social service and mental health professionals working with youth with EBD and their families
- assessment of community capacity to increase the range of services, create non-categorical options for youth with EBD and their families and identification of needs, gaps and barriers in the service system

Table 1
Project WRAP
Model System Components

Model System Components Identified in the Literature	Project WRAP Activities/Components	Phase I	Phase II
Needs Assessment and Planning	Systems Assessment	X	X
	Planning at Coordinating Council Level	X	X
	State Coalition		X
	Involve legislature		X
Constituency Building	Coordinating Council	X	X
	Wrap-Around Interagency Network	X	X
	Collaboration Around Target Cases	X	X
	State Coalition		X
	Illinois Federation of Families		X
Interagency Collaboration	Coordination Council	X	X
	Wrap-Around Interagency Network	X	X
Local Systems Development	Respite	X	X
	Parent Partners	X	X
	Parent Network	X	X
	In-Home Options	X	X
	School Inclusion Model		X
Modify Mental Health and Special Education Systems	Redirection of Department of Mental Health Residential funds	X	X
	School Inclusion Model		X
	In-Home Services	X	X
	Respite	X	X
	Mental Health in Schools	X	X
	Peer Support Programs	X	X
Technical Assistance Training	WRAP Training Network	X	X
	Coordinating Council	X	X
	Wrap-Around Interagency Network	X	X
	State Coalition		X
	WRAP Parent Network	X	X
	Illinois Federation of Families	X	X

The formal Needs Assessment process involved a two tiered assessment of service needs, service availability and service adequacy. A **service system needs assessment** questionnaire was mailed to parents of students in EBD special education programs, school personnel, community mental health and social service providers, regional directors of state social service, child welfare and education departments and other local human services such as the police department. This instrument identified sixteen services as critical components to a comprehensive system of care for the target population of youth with EBD. The questionnaire asked for an assessment of the current service provision level in these sixteen services. It also identified twenty five criteria for optimal service provision/best practices and asked for an assessment of the adequacy of the current service system in these specific categories. The questionnaire also asked for a narrative assessment of the most needed additions to or changes in the service system.

A second instrument was sent to a representative sample of parents of youth with EBD and asked for as **assessment of the service system and services for a specific child/adolescent.** Parents were given a "shopping list" of forty nine services and asked to rate them by need, by availability and by adequacy in meeting the needs of their child and family. They were also asked to identify three services they felt they needed the most. This identified youth's needs and the availability and adequacy of services to meet those needs. These were then assessed by both the school team and the mental health provider (identified by the parent) involved with the youth through a similar questionnaire.

Project staff quickly became aware that this more formal needs assessment process was just the impetus for creating a dialogue with parents, teachers and service providers who were frustrated and confused and also were initially unsure of how to describe or quantify their unmet needs. The following section describes other less formal, but ultimately more meaningful, methods of identifying service needs for this population including:

- **The WRAP Coordinating Council**, comprised of key policy makers and administrators from state departments and local agencies focused on policy, funding and service availability issues throughout Phase I. Areas of specific need which emerged included lack of respite and in-home services for families in west Cook. Respite units from a neighboring community were accessed for target cases and the development of similar units in west Cook County are now underway. Private providers and public agencies are involved in the development and planning of these services through the Coordinating Council structure. The need for additional school-based supports to create inclusive opportunities for students with EBD being returned from residential and day treatment was identified and is being addressed through a Wraparound in Schools (WAIS) model which the Illinois State Board of Education approved for funding beginning in July, 1993. Additional public and private funding streams for community-based alternatives are being pursued for these services.
- **The Case Coordination Committee**, comprised of clinical staff from local agencies, provided critical feedback in the assessment of the community's capacity to meet the needs of it's youth and families during Phase I. The decategorization of funding structures, family preservation/ parent support services, increased interagency collaboration and the development of respite services in the LADSE community were among the greatest needs identified through the case review process.
- **Parents sought out Project staff** to discuss their service needs in response to the Needs Assessment questionnaire. These parents appeared to be the most system involved, and were often the most discouraged about the gaps in services. The most common frustration expressed indicated that lack of in-home respite was a key factor in deciding if the youth remained in the home, or if placement was sought. These parents sighted the need for after-school and summer activities in the community that were inclusive of youth identified as students in EBD programs, the need for crisis intervention services and the need for programs designed to work specifically with youth diagnosed with Attention Deficit Disorder and their families.
- **Training sessions** were frequently a forum for parent-led discussions on categorical services and their unmet

needs. Parents asked for expanded options. These included funding for new community-based interventions and in home services, parent advocacy services, for someone to help them in developing resources, and strategies for evaluating service options.

- **Consultation to school teams** often highlighted barriers to services for youth with challenging behaviors, such as financial incentives for more restrictive services such as in-patient psychiatric hospitalization rather than after school treatment (partial) programs and respite. These consultations also highlighted the need for school-based mental health supports and increased parent involvement on school teams. Frustration with their ability to control aggressive behavior would cause school teams to choose a restrictive placement quickly.
- **Case planning assistance** was sought by school teams as they identified students at risk for more restrictive school or residential placement. Planning was done in conjunction with the parent, the school team, often including community service providers. Though service planning was limited to one or two planning sessions, this case involvement reiterated many of the findings from the formal needs assessment process, such as the critical need for case management services in the community and the need for family support services that were not within the traditional parameters of the mental health treatment. Other areas in case planning included: providing mechanisms to assure that planning is parent inclusive, that services are coordinated, culturally valid and comprehensive, that the implementation of services is monitored/evaluated, that changes or modification in services are made when needed and that outcomes are established.
- **School staffing and meetings** underscored many of the gaps in the existing service system. The disparity between recommendations for needed services, availability of services and financial feasibility in obtaining services was often profound. Comprehensive and coordinated treatment within accessible distance that is covered by insurance or is at reasonable cost was consistently an issue. Creating opportunities for interagency/multi-system planning involving mental health, social service, juvenile justice and school staff in partnership with the parents was repeatedly stated as an unmet need. Integrating wraparound case planning strategies at the school staffing was an effective strategy used to address this area. School-based consultations as well as school referrals to the Wrap Around Interagency Network (WIN) were also useful and will be continued in Phase II.
- **Resource development** efforts by Project staff led to an informal referral network within LADSE. School and mental health staff sought out Project staff for suggestions on resources and referrals for services. Approximately 100 parents and professionals asked for assistance in matching services with specific needs and the process itself became another needs assessment process. Finding psychiatrists who spoke family-friendly language, included the parent in decisions and consulted with school teams was one area of need. Insurance funding of alternatives to hospitalization and networking with other consumers of a specific service or service provider were also repeated needs.
- **The hands-on experience with the fifteen families in the pilot program** made the needs assessment process a very personal appraisal. Through the course of the pilot, WRAP staff became intimately aware of the needs of these families and the frustration in obtaining the supports and services necessary to address those needs. The need for family support teams, individualized and strength-based

planning, normalized service delivery in home, school and community settings cannot be overstated.

- **Through assisting local agencies in developing or expanding services** for target cases, WRAP staff became more aware of funding and policy obstacles. Service development included respite, in-home behavior management, parent advocacy and training.
- **Development of the Parent Partner and Buddy programs** brought WRAP staff in contact with other youth, families and agencies. The Parent Partners Program involved hiring parents as service providers for other parents. The Parent Partners provide support, advocacy training, resource development or other forms of assistance to parents. The Buddies program hired 17 to 30 year-old males to provide social and recreational experiences and opportunities for project students. The contacts established through the development and implementation of these programs provided valuable input to the needs assessment process. The consumer reported success of these two programs validated the need for normalized service options as well.
- **The Wraparound Interagency Network (WIN)** was created as a means of coordinating and integrating services for youth with emotional and behavioral disabilities and their families. WIN emerged as the interagency Coordinating Council expanded it's role to take on the function of an interagency referral and case coordination network. Following discussion of policy and funding issues at monthly meetings, the Council then convenes as the Wraparound Interagency Network (WIN). WIN provides support to parents and existing providers who are interested in developing wraparound plans which go beyond traditional service delivery models. WIN addresses the need for interagency coordination and provides a means for the identification of solutions to barriers in policy and funding guidelines as well as a way to create a system of care in the LADSE community. The development of WIN was also part of the systems assessment process. Through WIN, Project staff have expanded their service capabilities and their needs assessment base.
- **The WRAP Parent Network** became the founding chapter of the Illinois Federation of Families (IFF) and joined the Federation of Families for Children's Mental Health, a national parent advocacy organization. Through the IFF's parent advocacy efforts, WRAP staff continue to receive needs assessment information from the community at large. One of the areas of development is in locating and accessing appropriate services, learning how to navigate and work with our service system.

Table 2 summarizes the critical needs which emerged through the Project WRAP Phase I systems analysis.)

Discussion Of Findings

Throughout the needs assessment process parents and schools frequently requested more mental health services. Upon examination, however, it became clear that what they most often wanted was not what therapists and mental health agencies traditionally provide. Though labeled as a mental health service, parents were asking for a means of intensive coordination of interagency, multi-system planning and services, for a broad array of services to support them as parents in meeting the needs of their child with emotional and behavioral disabilities. This involved supports that would allow them the time and energy to begin to meet some of their own needs which often got buried under the vast needs of their child. Parents taught us that they want other parents, professionals who are much more personally, humanly and holistically involved, who are not blaming or pathologizing, and some

Table 2
Project WRAP
Critical Needs Which Emerged Through the Project WRAP Systems Analysis

Area of Need	Project WRAP Activities/Components
Family/Home	In-home respite and community-based alternatives to residential services
	Out-of-home and emergency respite; community-based shelter for MIRA youth mandating in-home family preservation services
	In-home family support/counseling/family preservation services to the family prior to any placement of a child in residential care
Parent Supports/Services	Parent led support groups
	Advocacy services
	Parent training groups that provide baby-sitting
Community/Recreational	Inclusive recreation programs in the community
	Supervised after-school programs providing normalized social activities
	Community-based (vs. home-based) therapeutic respite services
	Summer programming for youth with EBD
Schools/Educational	Development of models and techniques for inclusion of students with EBD in regular classrooms in neighborhood schools
	Increased and more meaningful parent involvement with school teams
	Intensive case coordination services that are school-based
	Day treatment in normal school setting for youth with chronic mental illness
	A change in the type of communication schools initiate with the parent: problem-solving and progress update contacts
	Creating true partnerships between schools and parents
	Truancy intervention that is outcome directed
	School teams that collaborate/plan meeting jointly when working with children from the same family in different schools
	School scheduling meetings that take the parents work schedule into account
	Family support for school staffing, using family-friendly language in school meetings
	Assessment services by an interagency team that is activated by school referral for more restrictive placement
	Eliminate home-bound status for behavioral reasons
	Peer support programs
	Making school staffings focus more on the child and less on the regulations and paperwork
	Reducing school suspension of students with EBD
	Brochure regarding parents rights and special education that are written in family-friendly language
	Behavior management consultants that can be utilized by school staff and family for unified planning prior to reintegration in home or district school, following day or residential placemen
Case Management	Individualized case planning assistance that is family inclusive and is provided to school team, community service providers and the family
	Case management services that work in partnership with the parent and focus on team development, development and coordination of services, accessing services and funding for services, monitoring and evaluation implementation of services, establishing normalized measurable outcomes.
	Increased interagency collaboration in case management
	Someone to help parents in identifying and evaluating service needs, options and providers

Table 2 (continued)

Psychological / Mental Health Services	In-home counseling services and supports
	Baby-sitting during in-office treatment
	Reduction in fragmented service delivery
	Multi-system involvement in comprehensive assessment and diagnostic evaluation
	Primary prevention programs in grade schools regarding drugs, gangs, dropping out and pregnancy
	Crisis intervention services
	Community-based hotline services
	School-based services to student and to school teams
	Community-based intervention and service models that are more comprehensive and normalized than in-office therapy sessions
	Need to reduce duplication in services
	Need for mental health provider to work in conjunction with other providers of service to family such as physicians and the extended family network
	Peer counseling programs for adolescents
Medical	Accessible and affordable drug testing
	Low cost health care
Training	Parents and school personnel: diagnostic labels and what this means in relation to needs and services
	Parents: learning how to navigate the human service and special education systems and advocate for services for their child
	Dealing with physical aggression in the school and home
	How to develop and implement effective school inclusion plans that involve teachers, parents and mental health
Funding Structures	Reallocation of funds support a broad array of home and community-based supportive services.
	Insurance funding of partial programs psychiatric hospitals
	Decategorization of funding/flexible dollars: needs-based not service-based planning
	Individual Care Grant use for funding of in-home service as an alternative to residential placement
	Funding for alternatives to in-patient care as well as for after insurance is depleted
	Funding for community-based services rather than placing services in institutional settings outside the community
	Insurance funding of respite services
	Eliminating financial incentives for more restrictive services
Resource Development: Information and Access	Wider access to information regarding public aid, medicaid, SSI and other funding streams for services regarding eligibility requirements and service information
	Parent networking regarding evaluation of services (consumer-based evaluations)
	Services for identifying resources, "brokering" services and funding for services for families

time for their marriages, their own lives, friends and work. The extent of need was most overwhelming in the area of parent support and the types of services that make an alliance with the parents to develop, access, fund and coordinate services to help their child. This includes case management with a focus on parent-driven and strength-focused planning as well as normalized services in more normal school, home and recreational settings.

Parents asked for services delivered by peers, parent led support groups, advocacy services and a customer mindset when it came to obtaining services. Some parents expressed a desire for in-home mental health services but the description was more in line with respite and behavior management consultation than therapy. Parents talked about placing their child in a psychiatric hospital but psychiatric hospitalization was never rated as a needed service. Parents stated they used them when services were not available in the community. The financial implications for the service system are obvious but family by family, they were often disastrous. What parents said they needed was someone to do an assessment of the youth, then work with the youth, parent and school on solutions, or out-of-home respite on a temporary basis. Parents overwhelmingly stated they needed to have someone help them navigate the service system, be that mental health, special education, medical, etc. They asked for someone to help them develop resources, access services and advocate in their behalf. Yet they rated case management as a low priority.

School teams said they wanted mental health services to be school-based. However, they felt it was most practical and useful to have clinicians available for on-site assessment, at school team meetings to assist them in planning, and as a resource for in-home services to work with the parents. They felt this type of service was more effective than seeing students during class time for therapy.

Final Comments

Perhaps because the youth in the WRAP Project pilot were labeled emotionally and behaviorally disordered, it seemed that parents and school personnel felt the need was in mental health. But what the more interactive needs assessment process determined was that adults (parents, school teams) wanted people to work directly with them in meeting the needs of youth. Prior services had focused on the youth and the problems behavior demonstrated by the youth. The system gap most readily identified was in services to the adults who live with, teach and guide these youth. Simplistic as it may sound, adults wanted the help.

Schools and parents want an alliance, want supports to better meet the requirements of their "job" with the youth. They talked about having a therapist or a social worker or teacher or parent include them in the communication loop, give them non-blaming suggestions, insights, feedback. What they want for their child is some place to go, someone to go with and something meaningful for them to do. They want normal things for their child, and a partner in helping them with the parts of their child's life that were the not so normal parts.

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Baseline Findings from a Study Focusing on the Mental Health of Children in Three Demonstration Project Sites in Texas: The School of the Future Project

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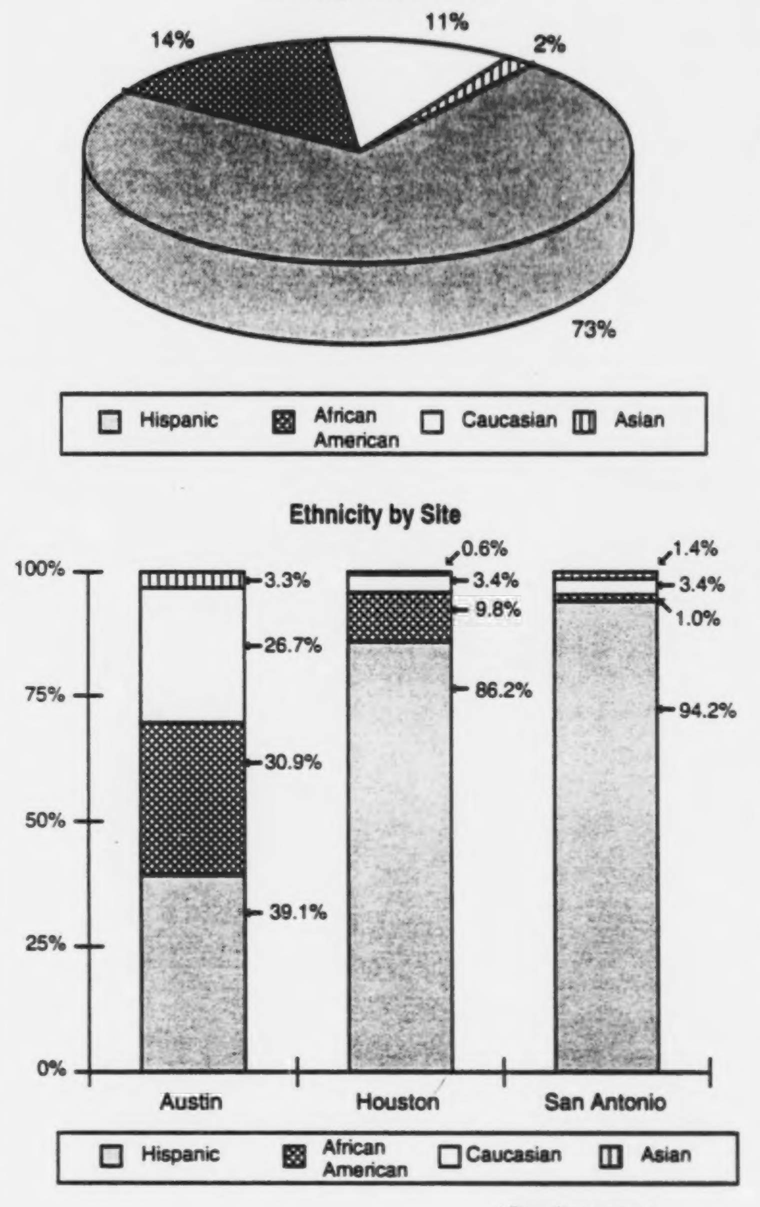
Data are being collected annually over a five-year period on approximately 80% of the students in 15 schools in Texas (4 in Austin, 6 in Houston, and 5 in San Antonio schools) participating in the evaluation of the School of the Future demonstration project (a school-based, coordinated health and human services program). The nationally recognized instrument developed by Dr. Achenbach measuring mental health has been administered to students in the six middle schools (grades 6-8). Teacher report data assessing students in the same area were collected in the nine "feeder" elementary schools (grades K-5). The initial results of the baseline mental health surveys collected and the exhibited differences between elementary and middle school students participating in the evaluation are discussed. The results support the importance of providing preventive social services at the elementary and middle school levels in Texas.

Introduction

The School of the Future Project, which implements and coordinates school-based health and human services for students and their families, has important implications for how public schools can be utilized more effectively in the 21st century. Recognizing the importance of documenting the project's impact, the Hogg Foundation for Mental Health, in addition to providing one million dollars in direct grant support, has committed another million dollars to indirect support, most of which is devoted to evaluation of the project. The evaluation plan for the School of the Future was developed through consultation with the directors of two earlier projects, James Comer (Comer 1980; 1988) and Edward Zigler (Zigler 1989), as well as a school-based service project in Philadelphia that is funded and evaluated by the Center for Education in the Inner Cities (CEIC) Project at Temple University (Center for Research in Human Development and Education 1990; Peng, et al., 1991).

Three of the four School of the Future sites are discussed in this paper: Austin, Houston, and San Antonio. The fourth site elected *not* to use the identical across-site survey instruments used by the other three sites, making comparison extremely difficult. Therefore, this fourth site is not included in the discussion.

Figure 1
Ethnicity Across Sites



* Based on surveys collected from each site.

Site Descriptions

Austin. The Austin School of the Future site is located in the far southeastern part of the city in an area known as Dove Springs. Dove Springs is a recently developed neighborhood with a high number of rental units and high population turnover. Because of these factors, few community services have been established.

The two schools, Méndez Middle and Widen Elementary, located on opposite sides of the area's main street, were built eight years ago. While school authorities deny that gangs are more prevalent at Méndez than at other schools in the district, a number of parents have relocated to avoid sending their children to Méndez. The population at the schools is diverse with (see Figure 1): slightly less than 50 percent of the students are Hispanic, 25 percent African American and 25 percent Caucasian. Approximately half of the students come from low income families.

Houston. Three schools in an area called "the Heights" form the nucleus of Houston's School of the Future. The Heights lies northwest of downtown along both sides of Interstate 10. The neighborhood is predominantly Hispanic and low income. The schools included are: Hogg Middle School, Brock Elementary, and Memorial Elementary.

The student population at the middle school has increased significantly over the past few years. There are now more than 1,100 students, 85 percent of whom are Hispanic. Three quarters of the children qualify for the federal free lunch program and more than 30 percent are from single-parent homes. Half the children are not in age appropriate classrooms. A needs assessment that was conducted at the beginning of the project indicated that 80 percent of the children living in the school neighborhood claimed one or more family members used non-prescription drugs. (Houston School of the Future Needs Assessment, 1991)

The Hogg Middle School was already the site of a highly successful dropout prevention program and has been receptive to other outside efforts to help children. The program serves students classified as "at risk," a category which includes 70% of the school's children. Recently, the dropout prevention effort has expanded to include drug abuse treatment and prevention services.

Memorial Elementary was built during the 1920s and has a student population of just over 500. Planned renovations over the past year added another 100 children to the school. Brock Elementary, built on land donated by a successful black businessman from the Heights, is smaller, with just 280 students. Both schools feed into Hogg Middle School and have similar demographic characteristics—predominantly Hispanic and low income children.

San Antonio. The J. T. Brackenridge neighborhood is heavily Hispanic and faces numerous obstacles for mental health and stability. Physical boundaries isolate the neighborhood from the rest of the city. Few industries or substantial employment opportunities exist in the area. Almost all of the school children live in poverty. Crime, family disorganization, and substance abuse are common. Malnutrition and maltreatment are persistent. The local service agencies are overloaded with problems to remedy. The school district is financially strained and when the program started, there was no viable PTA or corporate sponsor. School personnel are frequently involved in helping children and families solve social problems.

A part of the San Antonio Independent School District, the state's fourth-largest school district, J.T. Brackenridge Elementary is a relatively modern facility serving 950 students, preschool through grade five. It is located in the middle of the Alazán-Apache Courts housing project, which was dedicated by Eleanor Roosevelt in 1939 and is the oldest housing project in the country.

Well over 1,000 apartment units make up the Courts, though many units are boarded up and appear to be uninhabited. The Alázan-Apache Courts provide housing for over 1,000 families and 4,300 residents. Over half of the families with children are one-parent families. The Alázan-Apache Courts represent 18.6% of the total public housing population in San Antonio and 15% of the public housing project children. The average income of families in the Courts is just under $5,000.

Also serving this area is Tafolla Middle School, another large, modern facility. With an enrollment of 1,000 students, grades 6 through 8, Tafolla offers both mainstream educational offerings and a magnet language arts/ accelerated studies program. Almost all of Brackenridge graduates attend Tafolla, though a relatively small number of them are part of the accelerated language arts program.

Purpose

The findings from the School of the Future evaluation are used in several ways:

Assist in Site Planning. After data are collected, appropriate information is "filtered" back to the sites to help them in project planning. Aggregated information helps site personnel to prioritize program needs and implementation in the school to inform and educate local service providers on the school-based service approach.

Inform Key Decision-Makers. Research on the effectiveness of the school-based service approach will be provided to legislators and other key decision-makers. By demonstrating the benefits of the School of the Future concept, local, state, and/or federal support may be garnered for developing a school-based approach in other schools.

Develop a Blueprint for Replication. One of the objectives of the evaluation is to document the "successes" and "failures" in each of the project sites. This documentation, combined with other important data, such as budget figures, will provide valuable information to those interested in implementing school-based service projects in their communities.

Design

Data used for this paper were collected from students and their teachers in all schools participating in the project as well as identified "comparison" schools matched demographically with the experimental schools (see Table 1).

Data collection procedures have been standardized which make it possible to analyze similarities and differences in outcomes across the three sites as well as within sites between project and comparison schools. Again, standardized data collection procedures have been designed so an experimental-control comparison can be made.

The research is planned for a five-year period, but the data to be discussed here are from the first year of the project only. The data collected annually on students from the survey and the achievement data downloaded from the school computer files will be matched up on our data sets, enabling us to study the same students in the project sites and comparison schools over the five years of the demonstration project.

Measures

The focus of the School of the Future is the student and the ultimate goal is to improve the quality of life for the children in these schools and neighborhoods. One aspect of an improved quality of life for children is improved mental health. This aspect of the evaluation is the focus of this paper. Other data collected on students are: self-esteem, academic achievement (grades, standardized test scores, and attendance), and perceptions of school climate. These data are linked to the survey data collected on mental health. The discussion here, however, will look at the mental health survey data only. The following instruments comprise the core of the student information collected.

Youth Self-Report Form. Achenbach's Youth Self-Report Form (YSR), a version of the Child Behavior Checklist (Achenbach 1991a), is the core instrument in the student survey. Students are asked to respond "always true", "sometimes true", or "never true" to items asking about their everyday behavior over the past six months. Examples of items included are:

Table 1
Youth Self-Report and Teacher Report Forms by Ethnicity

	Ethnicity				
	Caucasian	Hispanic	African American	Asian	TOTAL
Instrument					
Youth Self-Report Form *	382	2215	454	52	3103
Teacher Report Form **	355	2959	439	54	3807
TOTAL	737	5174	893	106	6910

* Forms with less than 8 items missing (Total number of collected forms is 3258)

** Totals before parental consent considered (Usable total should be close to 90% of these figures)

- I daydream a lot
- I am mean to others
- I don't get along well with other kids
- I have trouble concentrating or paying attention
- I deliberately try to kill or hurt myself

When these items are grouped and scored as instructed, various aspects of a child's mental health can be measured. The syndromes measured include the following eight scales: withdrawn, somatic complaints, anxious/depressed, social problems, thought problems, attention problems, delinquent behavior, and aggressive behavior (and for boys only, self-destructive/identity problems).

This instrument also allows for a comparison of those completing the assessments to a national sample of children. The national sample has two normed groups for comparison: 1) children *not referred* for mental health services in the past 6 months ("non-referred" group); and 2) children *referred* for services in the past 6 months ("referred" group).

The YSR is recognized nationally, has extensive normative information available (Witt, et al., 1990), and has been tested and deemed appropriate for students in grades 6-8. There are 122 items in the YSR that take approximately 30 minutes to complete. It is administered during one class period in the classroom annually in the late Fall of the school year.

Teacher Report Form. Another version of the Child Behavior Checklist offered by Achenbach (Achenbach, 1991b) has been developed for completion by teachers on their students. The Teacher Report Form (TRF) is used with children in Kindergarten through 5th grade because these students are not be able to complete the self-report version.

This form, which contains the same basic problem items as the self-report version and also offers a normed sample of children as a comparison, is completed by almost 80 percent of the teachers for each elementary school student in their class and is done over a six-week period near the end of the school year. They are completed late in the school year so teachers have the time to get to know their students well enough to answer these important and sometimes difficult questions about them.

In the experimental and comparison sites, information is collected annually from teachers on all children in these lower grades through the use of the TRF. Teachers are compensated for their time in completing the assessments.

Results

Preparation for Data Analysis. There was an initial concern about using this instrument on this unique population of children, so two preliminary analyses were performed to determine the reliability of the data collected. A "global reliabilities analyses" and a "confirmatory factor analyses" were performed on the data. In the global reliabilities analyses, the Cronbach alphas were calculated for our population and then compared to the alphas generated for the Achenbach normed sample for both the YSR and the TRF (see Table 2). There were no significant differences in the alphas generated for the two groups.

In the confirmatory factor analyses, we tested various models to see if race or age effected the level of comprehension of the instrument. We concluded from these tests that the basic model fits across the various ethnic groups and that any existing cultural differences in interpretation and comprehension of the basic ideas conveyed in this instrument were not significant.

Elementary School Students. The results of the Teacher Report Form (TRF) analysis indicate that children in both the experimental and control sites in Texas more closely resemble the scores for the "non-referred" sample of children (see Figure 2). Since only a very few of the children in these schools participating in the evaluation have ever been referred for any kind of mental health service, the results shown

Table 2

A Comparison of the Reliabilities Obtained by Achenbach on the TRF and YSR with those Obtained by the Hogg Foundation on those Same Instruments During 1991-92

	Cronbach's Alpha TRF Achenbach Norms	Cronbach's Alpha TRF Hogg Foundation 1991-92
Girls (*N* = 1379)*		
Withdrawn	.83	.76
Somatic	.76	.80
Anxiety	.89	.84
Social Probs	.87	.81
Thought Probs	.63	.56
Attention Probs	.95	.94
Delinquency	.69	.73
Aggression	.96	.96
Internalizing	.91	.89
Externalizing	.95	.96
Total Problems	.97	.97
Boys (*N* = 1401)		
Withdrawn	.83	.77
Somatic	.72	.75
Anxiety	.88	.85
Social Probs	.85	.85
Thought Probs	.72	.65
Attention Probs	.94	.94
Delinquency	.70	.87
Aggression	.96	.96
Internalizing	.90	.89
Externalizing	.96	.89
Total Problems	.97	.97

	Cronbach's Alpha YSR Achenbach Norms	Cronbach's Alpha YSR Hogg Foundation 1991-92
Girls (*N* = 1781)		
Withdrawn	.59	.68
Somatic	.80	.79
Anxiety	.90	.84
Social Probs	.68	.59
Thought Probs	.71	.71
Attention Probs	.78	.72
Delinquency	.76	.64
Aggression	.86	.82
Internalizing	.91	.89
Externalizing	.89	.86
Total Problems	.95	.95
Boys (*N* = 1499)		
Withdrawn	.59	.67
Somatic	.77	.77
Anxiety	.86	.81
Social Probs	.68	.59
Thought Probs	.69	.68
Attention Probs	.75	.72
Delinquency	.76	.64
Aggression	.86	.84
Self Destructive	.76	.75
Internalizing	.89	.88
Externalizing	.89	.86
Total Problems	.95	.95

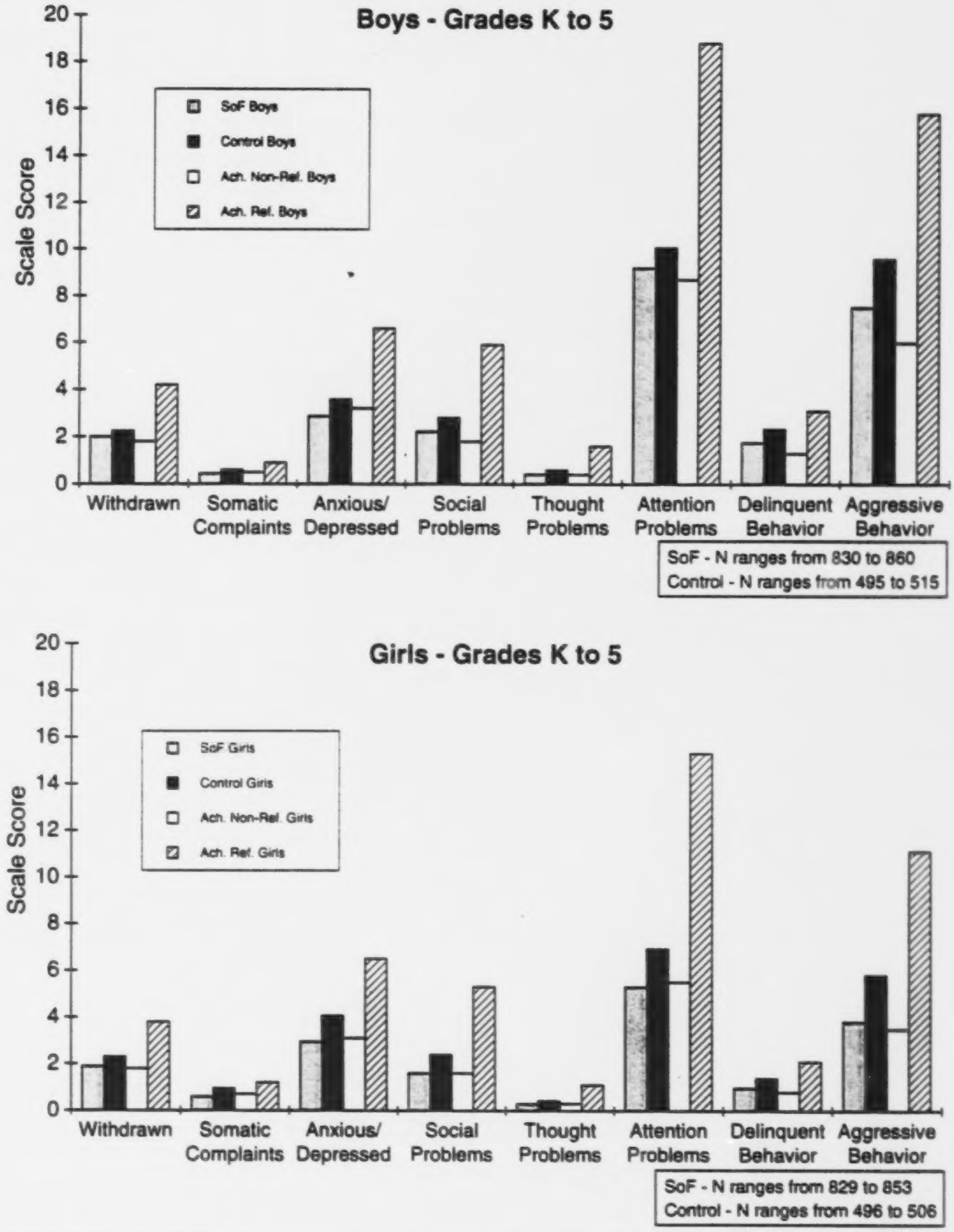
* All N's refer to Hogg Foundation Samples

here are not very surprising. However, there are some results that need to be mentioned.

The control school children show higher syndrome scores than the demonstration school site children for all syndromes. This holds true for both the boys and girls in these sites. It will be very interesting to see if the gap between the control and experimental sites widens further over time as mental and physical health services become increasingly available to only those students in the experimental schools.

Also, despite the fact that neither the boys nor the girls exceed or even equal the scores of the "referred" group of children, for several syndromes, the boys and girls in both the control and experimental sites show significantly higher scores than the "non-referred" group. Boys are above the "non-referred" group norm in the withdrawn, social problems, attention problems, delinquent behavior, and aggressive behavior syndromes. Girls are above the "non-referred" group scores only in the delinquent behavior

Figure 2



SoF - N ranges from 830 to 860
Control - N ranges from 495 to 515

SoF - N ranges from 829 to 853
Control - N ranges from 496 to 506

and aggressive behavior categories. Again, it will be interesting to monitor any changes in these findings over the five-year period of the project.

Middle School Students. The results of the Youth Self-Report (YSR) analysis present a very different picture than the results from the TRF (see Figure 3). The middle school students show many more problems than the elementary school students. In all syndromes, for both genders, the children participating in the project evaluation scored significantly higher than the "non-referred" group.

In some syndromes, these children show *even higher* scale scores than the "referred" group. This is the case for somatic complaints, social problems and thought problems for boys and somatic complaints for girls. All in all, the sample of children in both the experimental and control sites more closely resemble the "referred" group of children than the "non-referred" group. Although these children closely resemble the "referred" group of children, only a very few of the children in these schools have ever received any physical or mental health services.

Discussion

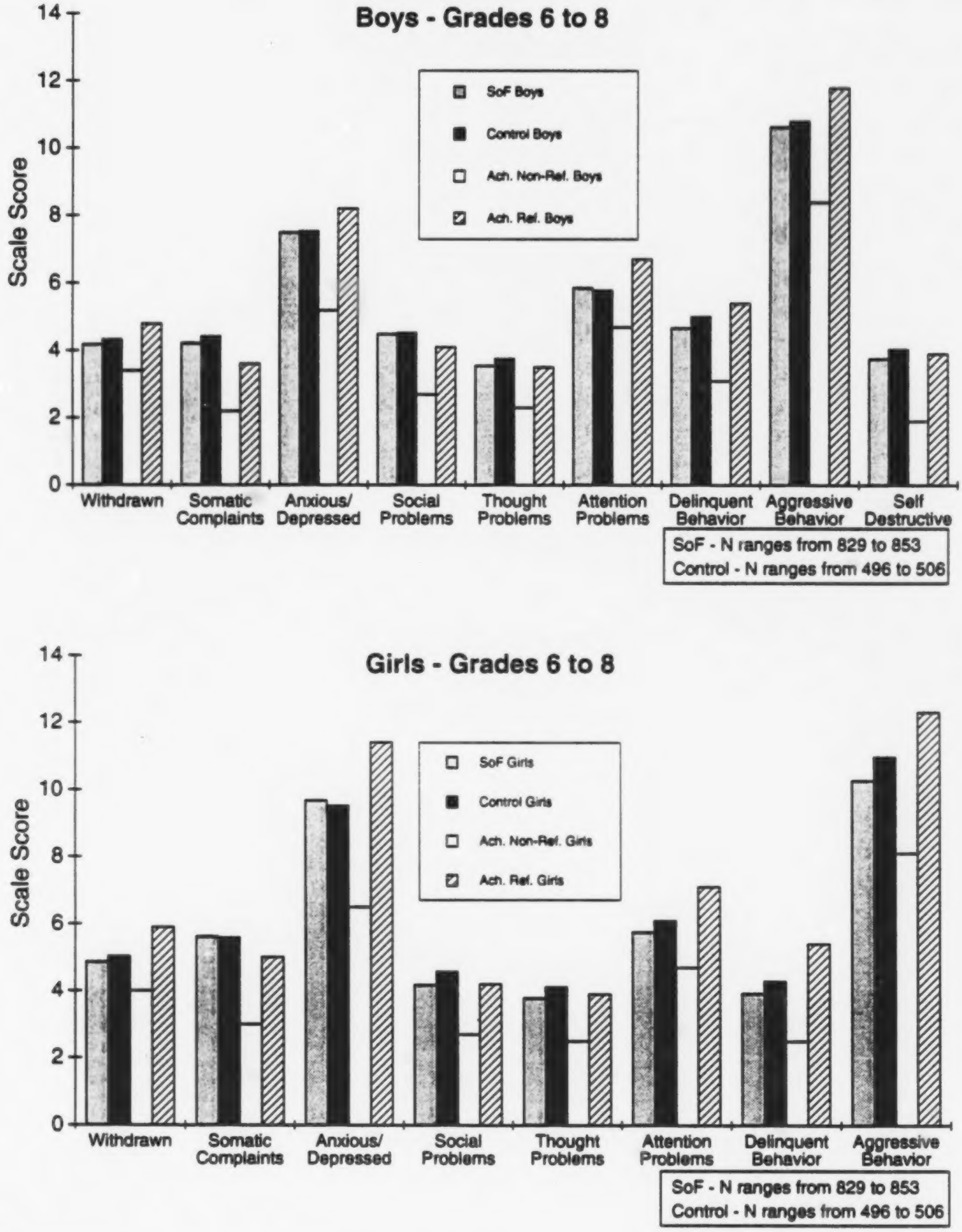
It is important to state here that the comparison between the student assessment results from the elementary school and the middle school is a not "clean" comparison because the elementary school assessments were rated by the students' teacher while the middle school assessments were completed by the students themselves. Despite the differences in perspectives from which the assessments of elementary and middle school children come, the variation in the results of those assessments is so dramatic that it is difficult to accept the idea that this variation is due entirely to differences in perspective.

These early findings support the argument for making physical and mental health services available in economically disadvantaged communities. The results also point to the critical need for prevention and early intervention services. In order to improve the mental health of all children in these communities, there must be an effort to offer preventive services to children in the communities by utilizing the schools as the distribution point for these services. These results call attention to the importance of offering these services to children as early as the elementary school level. Offering services at this early stage could decrease the number of crises that develop in the middle school and high school years.

Future Research

Currently data are being entered from the YSR surveys that were administered in the Fall school semester of 1992 and the TRF surveys distributed to teachers in the Spring semester of 1993. When these data are entered, analyses will be conducted to look for change in the various syndromes in the children from year 1 to year 2. Over the five-year period of the project, and most likely for several years after the project is completed, there will be an effort to follow the progress of those students involved in the schools that are currently participating in the evaluation. The plan is to follow these children as long as possible in a cohort and panel study of specific children to see if there is a link between availability of mental and physical health services and student academic achievement.

Figure 3


Boys - Grades 6 to 8
Scale Score
0
2
4
6
8
10
12
14
SoF Boys
Control Boys
Ach. Non-Ref. Boys
Ach. Ref. Boys
Withdrawn
Somatic Complaints
Anxious/ Depressed
Social Problems
Thought Problems
Attention Problems
Delinquent Behavior
Aggressive Behavior
Self Destructive
SoF - N ranges from 829 to 853
Control - N ranges from 496 to 506
Girls - Grades 6 to 8
Scale Score
0
2
4
6
8
10
12
14
SoF Girls
Control Girls
Ach. Non-Ref. Girls
Ach. Ref. Girls
Withdrawn
Somatic Complaints
Anxious/ Depressed
Social Problems
Thought Problems
Attention Problems
Delinquent Behavior
Aggressive Behavior
SoF - N ranges from 829 to 853
Control - N ranges from 496 to 506

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The City Lights Primary Prevention and Early Intervention Demonstration Project

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City Lights School has successfully incorporated a substance abuse prevention and treatment component into its existing psychoeducational day treatment program. With this addition, the school's services now include: remedial education, clinical and psychological services, vocational counseling and job development, and substance abuse prevention and treatment. A three-year grant from the Office of Substance Abuse Prevention (OSAP) initially funded the program, with a two-year extension enabling support to continue through August 1992. The substance abuse prevention program has addressed one key problem: preventing and arresting substance abuse among the growing population of high risk youth. Data were collected on dependent variables such as incidence of substance abuse, transition to more and less restrictive environments, recidivism, and independent living. Independent variables such as age, ward status, and school history were also tracked. The main findings were that the rate of criminal offenses dropped, and the rates of employment, training, and independent living increased.

Introduction

Since 1987, the range of services provided by City Lights School has evolved considerably. The substance abuse program, in particular, has led the school to widen the focus of its treatment. The emphasis now is not just on remedial education, but on the broader, more personal aspects of lifestyle, behavior, self-concept, and self-esteem. Given the increasing prevalence of crime, drug abuse, illiteracy, and unemployment among inner-city youths, clinical staff members have recognized the need to become more proactive, seeking to prevent substance abuse, violent behavior, and unemployment before they become deeply ingrained in young people's lives. The school's comprehensive approach to treating serious emotional disturbance now consists of remedial education; psychological counseling and treatment; vocational counseling and job development; and substance abuse prevention and treatment.

Goals

The goals of the demonstration project remained constant over the five year grant period, and are consistent with City Lights' overarching institutional goals. The project sought to accomplish the following:

1. Decrease the incidence of drug abuse among high-risk youths.
2. Reduce the risk factors for drug abuse among high-risk youths and their families.
3. Increase the resiliency factors of high-risk youths and their families.

One of the school's basic assumptions is that successful treatment of seriously emotionally disturbed, inner-city adolescents must be founded on a comprehensive, multi-faceted approach. Thus, in developing the demonstration project, City Lights has integrated the following services into its existing program:

1. A comprehensive Substance Abuse Prevention Program that builds self-esteem and increases coping skills and family support, while developing a positive peer culture among high-risk youths.
2. A Career Education and Job Placement Program which develops life-long job skills, self-sufficiency, and places high-risk youths in supported competitive employment.
3. An Internal Evaluation System to measure participant outcomes and identify factors that promote resiliency and decrease the risk of adolescent substance abuse.

The target population for this demonstration project was seriously emotionally disturbed, inner-city adolescents at City Lights School. These adolescents' parents typically offered little support or guidance, were physically or sexually abusive, and were often substance abusers themselves. Students at City Lights had histories of low academic achievement, learning disabilities, low self-esteem and poor coping skills. Additionally, they were prone to violent or delinquent behavior and sexual promiscuity. Many had already become parents.

The demonstration project has strengthened City Lights' efforts to increase students' resiliency to various environmental hazards. Improved literacy, self-esteem and problem-solving skills as well as accurate knowledge of the effects of drugs and alcohol, improve the likelihood that students can resist peer pressure to abuse substances. Development of life-management skills and job skills attempted to improve the student's chances of achieving independence, and thus reduce the appeal of the easy money afforded by drug dealing.

Research Questions

Researchers were guided by the City Lights Logic Model (shown in Figure 1) in formulating the following research questions:

1. What target population was served in the demonstration project?
2. How can adolescent drug use among high-risk African American adolescents be described?
3. How can the experience of African American adolescents at risk for substance abuse in a psycho-educational day treatment program be described?
4. To what extent are such adolescents placed in a less restrictive environment at the time of disposition and at follow-up?
5. To what extent are such adolescents working at the time of disposition and follow-up?
6. To what extent are such adolescents living independently at the time of follow-up?

Method

The demonstration project was assessed under a Real Time Prospective Design, as defined by Robins (1980). The approach is to select a sample at Time I, examine its members, introduce a treatment routine, and wait for the treatment to take effect before measuring again.

Figure 1
City Lights Logic Model

Resources/Conditions

If youths with:

Drug use and exposure to family/peer drug use

History of/current family dysfunction, physical and sexual abuse or neglect

Diagnosed psychiatric problems/severely emotionally disturbed

Chronic school failure/dropout/truancy/low academic achievement

Juvenile justice involvements, delinquent/violent behavior

Low employment and independent living potential

Lack of cultural pride/awareness

Program Activities

Participate In:

Educational Program
- Basic remedial academics
- Comprehensive Competencies Program
- Physical education

Clinical Services
- Intake
- Groups/Individual Psychotherapy
- Clinical Meetings
- Family Counseling
- Case Management
- Aggression Replacement/Crisis Intervention
- Psychoeducational Milieu

Substance Abuse Prevention/ Health Education Activities
- Groups/Life Management Skills Training Center
- Peer Education
- Substance Abuse Counseling

Career Education and Job Placement
- Group/Career Planning
- Pre-Work Preparation and Life Skills Education
- Job Placement and Support

Intermediate Outcomes

They Learn:

Reading/Language/Math skills

Self-esteem, self-control and the value of support systems (peer, school, family, neighborhood)

To attend school regularly and to stay in school

To be a functioning, productive member of support systems

To communicate/interact with support systems to reduce risk factors

Problems-solving and life management skills

The effects of drugs, and how to avoid abuse

Healthful lifestyles

Long-Term Impacts

And Are Empowered To:

Work Towards:
- Further school or training program
- Competitive employment
- Less restrictive environments
- More extensive support system relationships, including formation of new relationships on own initiative
- Lead drug-free lives
- Independent living in the community
- Passing on their gains to other family members, children, and community
- Perpetuating cultural traditions
- Developing peaceful communities
- Obtaining GED
- Self-advocacy and self-determination

Data Collection Procedures

Data were collected at admission, disposition, and follow-up. Sources of data were the intake interview, conducted by the student's social worker, during which demographic and behavioral data were collected, the TABE pre-test, administered prior to entry, in-program administration of the Substance Use Scale, the TABE post-test, typically given shortly before disposition, and the follow-up interviews, conducted over the telephone by the research analyst six and twelve months after disposition.

Participant Sample

A random sample of 25 students was drawn from a overall pool of 229 students who were enrolled in the program between September 1989 and May 1992. Chi-square and T-test results revealed no significant differences between this sample of 25 and the rest of the students in the database on any of the key independent variables, indicating that this is indeed a representative sample.

Student Demographics

City Lights' student body is composed entirely of District of Columbia residents. Table 1 displays the main demographic variables used to define the school's population. Student characteristics are derived from two earlier studies (L'Homme, 1987; L'Homme & LaCount, 1991) and data from the two-year extension (Note that data from 1987 have been provided as available).

All students admitted to City Lights have been certified as seriously emotionally disturbed as defined by Public Law 101.476. Many have received additional psychiatric diagnoses, derived from the Diagnostic and Statistical Manual III-R (DSM-3R). In 1992, 30% of the student population had been diagnosed as character or conduct disordered, and 58% had a history of depression.

Crime, particularly violent crime, among adolescents in D.C. has been on the rise for many years. City Lights has witnessed this trend firsthand. In 1989, 60 percent of the school's incoming students were offenders. By 1992, this figure had risen to 68 percent. Furthermore, although the trend has not been documented, experienced program staff members feel that felony charges are much more common among recent incoming students than in past years. This trend exemplifies the marked changes in the student population—away from minor crimes, and delinquency, and towards more serious offenses, drug trafficking, and substance abuse.

Results

The main focus of City Lights' research is on how the school's program affects students lives, and how they fare after leaving the program. To this end, researchers compiled data on a wide variety of variables—from public assistance received to substance use. Table 2 summarizes the most recent longitudinal data, derived from the four data collection points, for the main dependent variables.

Table 1
Participants at Admission

Participant Characteristics	1987	1989	1992
Average age on admission		17.9	16.7
Average months in program		9.9	9.0
Males	82%	65%	74%
Females	18%	35%	26%
African-Americans	100%	98%	99%
Wards of D.C.	36%	23%	25%
Victims of Abuse		39%	41%
Student parents		24%	16%

Table 2
Dependent Variables

Variables	Admission	Disposition	Follow-up 1	Follow-up 2
Employment	44%	28%	48%	60%
Vocational Training	9%	6%	7%	19%
Offenders (Recidivism)	68%	18%	4%	4%
Substance Abuse	88%	80%	60%	60%
Independent Living	0%	4%	4%	28%
School/Work/Training	N/A	32%	76%	76%
Less Restrictive Environment	40%	80%	92%	88%

Table 3
Types of Substance Abuse

Substances Used	Admission	Disposition	Follow-up 1	Follow-up 2
Cigarettes	20%	20%	16%	12%
Marijuana	26%	30%	7%	6%
Cocaine	3%	1%	0%	0%
Crack	1%	0%	0%	0%
PCP	0%	0%	0%	0%
Meth-Amphetamine	0%	0%	0%	0%
Heroin	0%	0%	0%	0%
Beer	58%	66%	37%	44%
Wine	49%	57%	20%	6%
Liquor	21%	23%	3%	13%
Other	0%	0%	0%	0%

Table 3 displays incidence of student substance use by substance type.

Academic Performance

The changes in student TABE test scores reflect the mean difference between pre- and post-test results among members of the participant sample. The TABE is administered and scored by the school's educational diagnostician. Test scores are given in grade-equivalent form (e.g., a score of 5.6 reflects achievement to the fifth grade, sixth month). Results showed that for this sample, reading increased by 0.63 grade levels per 100 hours of instruction, language increased by 0.51 grade levels per 100 hours of instruction and mathematics increased by 0.73 grade levels per 100 hours of instruction (see Table 4).

Table 4
Academic Gains

Subject Area	Pre-Test	Post-Test	Average Gains	Gains per 100 hours of instruction
Reading	5.62	6.18	.56	.63
Language	4.95	5.41	.46	.51
Math	5.81	6.46	.65	.73

Discussion

Analysis of these results suggests several conclusions about the program. First, and perhaps most importantly, members of the participant sample showed very encouraging progress in staying out of correctional facilities after leaving the program. Only one member of the 25-member sample was in a correctional facility twelve months after disposition. There is reason to believe that sampling bias may have influenced this result, since students contacted are less likely to be in legal trouble, and the participant sample is admittedly small. But the four percent rate of recidivism is striking in contrast to the 68 percent of the population with a history of criminal offense at admission. Whether City Lights's treatment is solely or primarily responsible for the positive change is debatable, but worth further study.

Another promising and striking result was the rate of students involved in school, work, or training at the twelve-month follow-up. Seventy-six percent of the sample was engaged in one of these activities, with a full 60 percent being employed. This is an encouraging employment rate, especially given the sluggish economy and extremely high levels of unemployment in the African American community. In 1991, The DC Department of Employment Services reported that 21.7% of African Americans age 16-19 were unemployed; among people age 20-24, this rate is 22%. Taken together with the low rate of recidivism, these data suggest that students are at least succeeding in meeting their basic needs in the increasingly violent and economically depressed neighborhoods in which they live.

The independent living statistic is substantially lower, but is perhaps somewhat misleading. Although only 28 percent of the sample was living independently twelve months after leaving the program, 65 percent of the sample was living at home (thus under supervision) at that time. Although the program was designed to enable the youths to maintain their own households, the effect of the current recessionary economy cannot be underestimated. Many students who could have afforded apartments in years past, were unable to do so during the data collection period. Recently, increasing numbers of middle- and upper-class young adults have taken to living at home into their twenties in order to save money, seek suitable employment, and plan for the future. It is reasonable to suppose that at least some of the school's less privileged students may have decided to live at home for many of the same reasons.

Despite the low rate of independent living, the rate of students living in less restrictive environments (LRE) was extremely high. The LRE statistic represents students living in situations other than correctional facilities or psychiatric institutions, and indicates the opportunity to achieve employment, further education, and independent living. The 88 percent figure at the second follow- up was a substantial increase over the 40 percent at entry, and suggests that the program is succeeding in integrating students into the community.

Conclusion

The results of the current study taken with the findings of previous research (L'Homme, et al., 1987; L'Homme & LaCount 1991) have highlighted the complex nature of City Lights' mission. The causes of students' conditions, and required treatment, are not easily determined. Consequently, the school's multifaceted psychoeducation program addresses multiple risk factors, and attempts to build a variety of resiliency factors in its students. Because one youth service organization cannot successfully respond alone to the problems faced by inner-city adolescents, the school relies on interagency cooperation, and continually works to develop such collaborative relationships. Given the harsh environments in which City Lights students live, one day's success can be followed by another day's crisis. Their progress is fragile; thus, students require gradual and persistent treatment.

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Attitudes of Regular Teachers and Administrators Toward Mainstreaming (Inclusion)

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This study investigated attitudes of elementary school personnel toward the placement of children with disabilities in regular classes, using a modified form of the Attitude Toward Mainstreaming Scale (ATMS). Subjects included 64 principals and 282 regular classroom teachers who were randomly selected by schools. Attitudinal factors were comparatively analyzed between and within groups. No significant differences between the two groups were apparent. However, within groups, a significant difference was found with respect to coursework in Special Education. Results support the use of attitudinal assessment components and inservice education as necessary parts of a planned mainstreaming endeavor.

Introduction

Despite the fact that the Education for All Handicapped Children Act has been in effect for nearly two decades, one of its major provisions has yet to be fully accepted by many educators. This provision which is embodied in the "least restrictive environment" clause of Public Law 94-142 involves the inclusion of students with disabilities in regular classrooms along with their non-disabled peers, and this process has been termed as "mainstreaming."

Whether we label the process as mainstreaming, inclusion, or integration, the concept has become an integral part of the American educational system and cannot be side-stepped by teachers or administrators. Public Law 94-142 has become a national tool through which state and district level policy may materialize (Quinsenberry, 1981). Therefore, the most difficult tasks facing administrators and teachers are those which concern the mandates of the law and their impact on the kind of educational programs the school district will offer to the students (Hepner & Crull, 1984).

Because principals and teachers are responsible for mainstreaming in the schools, it is imperative that the policy makers recognize their feelings and attitudes toward this process and the effect these attitudes have on the success of the mainstreaming efforts.

The purpose of the present study was to examine the attitudes of elementary principals and regular classroom teachers toward mainstreaming students with disabilities in South Carolina. The following hypotheses were tested: (1) that there would be no significant difference between the attitudes of principals and regular classroom teachers and (2) there would be no significant difference in attitudes between the two groups when demographic variables are controlled.

Methods

Sample

The original sample for the study consisted of 500 teachers and 100 principals from 100 elementary schools that were randomly selected from rural and urban school districts throughout South Carolina. Each principal and one teacher in each grade level (1-5) were asked to complete a nineteen item survey and mail it directly to the researcher by means of a self-addressed envelope. Sixty-four elementary principals and 282 regular classroom teachers from 64 elementary schools comprised the sample of this study.

Instrumentation

The research instrument used in this study was modified from the *Attitude Toward Mainstreaming Scale* (ATMS) developed by Berryman, Neal and Robinson (1980). The modified scale contained nineteen six-point likert-type items derived from a pool of attitudinal statements concerning the efficacy of mainstreaming handicapped students in general and those with specific disability types.

Reliability coefficients for three distinct categories of factors (Learning Capability, General Mainstreaming, and Traditional Limiting Disabilities) ranged from .74 to .84 with a total scale alpha of .89.

The Statistical Package for the Social Sciences (SPSS) was used to analyze the data. In addition to descriptive statistics, the one-way and two-way Analysis of Variance Procedures were used to test the hypotheses. The Sheffe procedure was utilized for further post hoc tests. The level of significance was established at the .05 level of probability.

Results and Discussion

The one-way ANOVA was employed to evaluate the relationship between the two groups (principals and teachers) on three distinct categories of measures on mainstreaming: Learning Capability (LC)-inclusion of capable learners, Traditional Limiting Disabilities (TLD)-inclusion of those traditionally out of the mainstream, and General Mainstreaming (GEN)-acceptance of the concept itself. These three subscales constituted the total scale. The resulting group means, *F* and *p* values are presented in Table 1. For two subscales and the total scale, differences between the groups were not statistically significant at the .05 level. These findings clearly suggest that principals and regular teachers agree on the inclusion of capable learners, and perhaps feel that intellectual limitations are more serious than other limitations. This finding is consistent with

Table 1

Results of ANOVA on the Total Attitudes Toward Mainstreaming Scale

Subscales	Principal (N = 64) Mean	Teacher (N = 282) Mean	F	p
LC Subscale	4.410	4.317	.624	.430
TLD Subscale	3.255	3.169	.324	.570
GEN Subscale	3.815	3.570	5.269	.022
Total Scale	3.977	3.021	2.419	.121

Note. LC = Learning Capability; GEN = General; TLD = Traditional Limiting Disabilities.

the research results of Koster (1987) in which students with average ability and physical disabilities were accorded higher expectations than other labeled students. Neither principals nor teachers supported the inclusion of students with cerebral palsy who cannot control movement of limbs. Perhaps both groups are aware of the level of distractions this involves and share concerns and possible fears about classroom factors that can inhibit learning. This notion is supported by findings of Shotel, Iano, and McGettigan (1972); Martin (1976); and Jones, Gottlieb, Guskin, and Yoshida (1978) in which the hesitation of teachers to accept handicapped students in their classrooms was explored.

The fact that the groups were significantly different on the GEN subscale indicates that the groups do not agree on the concept of mainstreaming as presently implemented. Some support was found in research by Hartnett (1979) and Gottlieb (1981) in which differences were found in teachers' and principals' perceptions and concerns relating to mainstreaming. Any inference from these findings, however, should be tempered with the realization that (1) for years an acceptable practice for regular education teachers has generally been to gear instruction to the typical learner without making many modifications for atypical learners and (2) the current trend toward mainstreaming has brought an array of methods and strategies which have contributed to a variety of forms of inclusive practices throughout local school districts; therefore, perceptions of school personnel may be necessarily based on different local practices.

Similarly, the two-way ANOVA was employed to determine the effects of demographic variables on the attitudes of the groups on each subscale and on the total scale. Four variables (Level of Education, Race, Teaching Experience, and Coursework in Special Education) were determined to be statistically significant at the .05 level. Table 2 presents the results of the two-way ANOVA. The mean scores for various groups based on demographic variables are reported in Tables 3-6.

The level of education for the principals and teachers had a significant effect on the LC and TLD subscales. Those with Masters degrees or Masters degrees plus thirty hours experience had overall higher means. Post hoc comparisons using the Scheffe Test showed those with Masters + 30 hours accounted for the difference among groups. These findings suggest that these degree holders were more positive about mainstreaming than other groups, a finding contrary to that of Kelpsh (1984) in which those with doctorate degrees were more positive.

Cell means on race revealed that Caucasion had higher mean scores than their counterparts on the LC subscale whereas African Americans had higher mean scores than whites on the GEN subscale. Post hoc comparisons indicated a definite difference between the two groups. The

Table 2
Results of ANOVA on Demographic Variables

Scale	Source	Mean Squares	*F*-Ratio	*df*	*p*
LC	Degree	118.196	2.561	4	0.038
	Race	436.971	9.863	2	0.000
	HRSP	366.684	8.469	4	0.000
GEN	Race	225.942	6.180	2	0.002
	Position	122.566	3.352	2	0.036
	HRSP	89.194	2.361	4	0.053
TLD	Degree	29.808	2.831	4	0.025
	Experience	32.843	3.120	4	0.015
	HRSP	33.374	3.179	4	0.014
Total	HRSP	1124.102	6.243	4	0.000

Note: HRSP = Hours in Special Education coursework.

Table 3
Mean Scores by Degree and Position

Subscale	Degree	Principal	Teacher	Total
LC Subscale	BA	-	34.14	34.14
	MA	35.08	35.05	35.05
	MA + 30	38.18	36.60	37.69
	EDS-DOC	34.52	32.00	34.41
	Total	35.20	34.47	34.60
TLD Subscale	BA	-	9.76	9.76
	MA	9.04	9.14	9.12
	MA + 30	11.36	12.80	11.81
	EDS-DOC	9.29	12.00	9.41
	Total	9.61	9.48	9.50

Scheffé Test: Group II vs. Group III (MA + 30)

reason for the distinct difference between these groups is not immediately apparent. However, results strongly suggest that African Americans and Caucasians differ on some strategic aspects of mainstreaming which may be due in part to historical events surrounding the improper placement and subsequent mistreatment of minorities pinpointed by the Brown decision (Quinsenberry, 1981; Raske, 1977)

The significant effect of experience was shown on the TLD subscale where principals and teachers with 20 or more years of experience had lower mean scores than those with less than nine years. This suggests that experience is negatively related to attitudes toward mainstreaming. This is somewhat supported by findings of Chueca Y Mora (1986) in which a strong relationship was found between experience and attitude toward mainstreaming. The number of hours taken in Special Education course work had the most pervasive effect across scales. Principals and teachers with sixteen or more hours of coursework had higher mean scores than those in all other groups. This finding suggests that coursework in special education is positively related to attitudes toward this inclusive practice in education.

Table 4
Mean Scores by Race and Position

Subscale	Race	Principal	Teacher	Total
LC Subscale	African American*	31.82	32.47	32.30
	Caucasian*	37.20	35.11	35.47
	Total	35.20	34.43	34.51
GEN Subscale	African American*	29.45	31.08	30.65
	Caucasian*	30.83	27.81	28.29
	Total	30.30	28.45	28.80

*Scheffé Test: African American vs. Caucasian

Table 5
Mean Scores by Experience and Position

Subscale	Experience	Principal	Teacher	Total
TLD Subscale	< 9 years	8.33	10.21	10.16
	10-14 years	9.92	9.29	9.38
	15-19 years	9.47	8.67	8.83
	20 + years	9.61	9.48	9.50

In conclusion, it is apparent that principals and regular teachers support the inclusion of learners with disabilities in varying degrees. Results of this study showed that the degree to which these educators supported the practice of mainstreaming was influenced in part by demographic variables, views of the inclusion concept itself, and by other factors such as the intellectual capability of the student with disabilities to learn, and the potential of the student to cause classroom disruptions.

It is important that state and local policy makers understand educators' feelings and attitudes toward the inclusion of students with disabilities in the mainstream and the level of their willingness to implement the idea of mainstreaming in South Carolina. This study has contributed toward the achievement of that goal. Results imply that a comprehensive local level inservice component to assess the general attitudes and feelings of educators

Table 6
Mean Scores by HRSP and Position

Subscale	HRSP	Principal	Teacher	Total
LC Subscale	Less than 6 hrs.	35.52	34.11	34.33
	6-9 hrs.	36.63	34.41	34.95
	10-15 hrs.	35.25	33.73	33.96
	16 + hrs.*	40.00	38.83	39.00
	Total	35.20	34.47	34.60
GEN Subscale	Less than 6 hrs.	30.86	28.02	28.47
	6-9 hrs.	29.00	29.29	29.22
	10-15 hrs.	27.25	29.18	28.88
	16 + hrs.	33.57	30.50	30.94
	Total	30.30	28.49	28.83
TLD Subscale	Less than 6 hrs.	9.90	9.50	9.56
	6-9 hrs.	9.00	9.18	9.14
	10-15 hrs.	10.25	8.41	8.69
	16 + hrs.	12.00	10.69	10.88
	Total	9.61	9.48	9.50
TOTAL SCALE	Less than 6 hrs.*	76.29	71.63	72.36
	6-9 hrs.	74.63	72.88	73.31
	10-15 hrs.	72.75	71.32	71.54
	16 + hrs.*	85.57	80.02	80.82
	Total	75.11	72.44	72.93

*Scheffé Test: Group I (-6) vs. Group IV (16+)

Note: HRSP = Hours in Special Education Coursework

periodically toward mainstreaming is essential. This will help the local and state administrators in education to evaluate the effects of various mainstreaming strategies in South Carolina.

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Perceptions and Experiences of Special Educators Regarding the Inclusion of Students with Emotional Behavioral Disturbances

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There has been considerable debate regarding the full inclusion of students with emotional behavioral disturbance (EBD). Thus far the research has been inconclusive as to the benefits of integrating all students in regular education classes. The present study examines the impact of inclusion on special educators working with nine children with EBD, who were placed in grades 2 through 7. Seven special educators were interviewed and their responses lend preliminary support to the inclusion of students with EBD in regular classrooms. Further research is needed with special education teachers who work in schools that include all children within the regular education classroom.

Introduction

As part of the requirements for Public Law 101-476 all children are entitled to public education in the "least restrictive environment." Furthermore, these students should also be able to receive necessary specialized services within the regular education setting (Gartner & Lipsky, 1987; Stainback & Stainback, 1987).

Despite P.L. 101-476, Gartner and Lipsky (1987) have indicated that nationally only 12% of those children with emotional behavioral disturbances (EBD) are in general education classes. This ranges from 0% in four states to 74% in Alabama. Based on the data, it appears that the notion of including students with disabilities in regular classrooms, particularly those students classified as EBD, is a controversial one.

The proponents of inclusion have argued that a dual system (regular and special programs) of education is not necessary to meet the instructional needs of students (Stainback & Stainback, 1984). Moreover, studies have not shown significant benefits for children who are in segregated special education programs. In fact, the research has indicated that students with developmental disabilities who were included in regular classes tended to have better academic performance, self-esteem, behavior, and emotional adjustment than those who were in segregated settings (Gartner & Lipsky, 1987). In addition, inclusion into regular classes appeared to be highly successful, both academically and socially, for the majority of students with developmental disabilities if adaptive, individualized programs are in place (Stainback & Stainback, 1984).

Advocates for a unified system of education also report other potential benefits of including "special education" students in regular classes. First of all, the need to classify students as either "special" or "regular," which generally stereotypes these children, will diminish. Collaborative efforts between regular and special educators will be facilitated, eliminating the unnecessary competition and duplication among general and special educators, and promoting the cooperation and teaming of resources to meet their instructional goals (Stainback & Stainback, 1984).

Another benefit of inclusion, with an individualized program for each student, is that all students, as opposed to only those who are labeled "special," will be eligible for instructional and related services (e.g., occupational therapy, social skills training, counseling, etc.) as well as to access support personnel, learning materials and other resources. Moreover, by including all students in a unified, heterogeneous system, there will no longer be a need to approach individual differences or characteristics as a means to classify or categorize, but instead to appreciate them as part of the individual (Stainback & Stainback, 1984).

Those who oppose inclusion state that including students who "vary in instructionally significant ways" (Kauffman, Gerber, & Semmel, 1988, p. 10) will confront educators with a difficult decision. Due to economic necessity, they will be forced to choose between maximizing the mean performance of their class by concentrating the resources on improving the performance of the more able students, or creating a smaller variance in performance for the class of students, which would involve concentrating the resources on the least able learners. According to those who propose maintaining a segregated system, in order to meet the instructional needs of those who are mildly handicapped and low performing, the resources and supports for their education must be protected. Although this can be accomplished within the regular classroom setting, these services must be identified as "special," "remedial," or "supplemental," to keep them separate (Kauffman, et al., 1988).

Kauffman, Gerber, and Semmel (1988) also state that including students with disabilities and doing away with labeling them may be just as or even more detrimental to them. Studies have indicated that students with poor academic performance who are not labeled as handicapped may be rejected more often than those who are classified as disabled. Furthermore, research findings regarding social outcomes of inclusion show that children with mild handicaps who are placed in the regular classroom setting do not experience an improvement in their self-concept (Kauffman, et al., 1988; Braaten, Kauffman, Braaten, Polsgrove, & Nelson, 1988).

Clearly, the inclusion of all students in the regular classroom setting is a much debated topic. As a result of the Vermont Act 230 of 1990, the state of Vermont is now responsible for educating all students in regular classes within their local schools. According to Giangreco, Dennis, Cloninger, Eddman, & Schattman (1992), most school districts in Vermont are providing integrated educational programs to students with developmental disabilities. The present study sheds some light on the perceptions and experiences of special educators regarding the impact of inclusion for students with emotional behavioral disturbances (EBD).

Methods

Subjects

The participants in this study were seven special educators who served as case managers for students with emotional behavioral disturbance. These students met the federal educational definition of severe disabilities and emotional behavioral disorders (Individuals with Disabilities Education Act of 1990, P. L. 100-476) or Vermont's Act 264 (Vermont Act 264, 1988) definition of severe emotional disturbance.

The students were enrolled in 2nd through 7th grade and attended general education classes within their local elementary and middle schools. The schools were also participants in the Best Practices for Educating Students with Serious Emotional Disturbance in their Local Public Schools and Communities Project, a federally funded statewide service providing technical assistance and training to develop programs for educating Vermont children with emotional behavioral disturbance in the regular classroom environment.

All of the special educators in this study were female. Their years of special education experience ranged from 2-16 years; the range of experience working specifically with children with EBD covered a span of 2-12 years. In addition, they had taught within an integrated setting for a period between 1-12 years. With the exception of two educators, the highest level of education obtained by these teachers was at the Masters Level, with three of them having their degrees in special education. These three educators also had special degrees/certification in resource room teaching and serving as a consulting teacher. Two of the teachers had completed additional coursework that included: family counseling, testing and sign language, working with children with EBD, and cooperative learning.

Data Collection Procedures

Data were collected by one of five researchers. Each special educator was interviewed on two occasions (between November 1991 and June 1992) for approximately 30-60 minutes. A semi-structured interview format was used to give the special educators the opportunity to share their perceptions and also to enable the interviewer to explore responses with follow-up questions. All interviews were tape recorded with the permission of the informant.

Each interview began with an explanation of the purpose of the research. The educators were informed that their responses would be confidential and that participation in this study was strictly voluntary. Information regarding teaching experience, training, and background were collected at the beginning of each interview. At the end of each interview, the teachers had the opportunity to ask any questions or provide comments.

Data Analysis

Thirty-five codes were developed by the research team to describe the interview data. The transcripts were then categorized according to these codes. Inter-rater reliability exceeded 80%. After the initial coding of the transcripts, the researchers re-coded the interviews by adding or dividing the previously coded data. The final codes then enabled the research team to identify and categorize emerging themes.

Ethnograph (Seidel, Kjolseth, & Seymour, 1988), a text sorting computer program was used to assist in sorting the interview data by code. Reports were then generated based on the 35 codes which grouped the data into related categories. This enabled the research team to identify themes and sub-themes that were considered for analysis. The themes were then classified as positive, neutral, or negative responses.

Member Checks

Once the interview data was analyzed, the preliminary findings were sent to the seven special educators. The special educators were asked to read the results and to indicate: a) whether the data protected their anonymity, b) whether their opinions and quotes were presented accurately, and c) whether the themes represented their responses. This was based on the member check protocol developed by Giangreco et al. (1992). Teachers were also given the opportunity to write in any comments to assist the researchers in better understanding their perceptions. A stamped, self-addressed envelope was provided to the educators to send their responses back to the research team. Participants who did not respond within two weeks were contacted by phone to answer the member check questions verbally.

Results

With the exception of one participant, the special educators in this study felt that inclusion had made a positive impact on their professional and personal lives. One of the primary benefits was that the educators felt they were able to work as a team around these students. A special educator who served a third grader felt that working collaboratively made her job "easier," allowing her to draw on "others' expertise" in dealing with these children. A special educator in 2nd and 3rd grade stated that "inclusion has affected me because you spend a lot more time consulting with teachers, instead of working directly with children." Other special educators also addressed the issue of inclusion facilitating collaborative teaming with regular educators.

> *There's positives working cooperatively. How has it affected me? Learning how to take in. . . being an advocate for kids through special education, but at the same time looking at a broader picture. Including general educators or special teachers. I have always believed kids should be included.* (special educator in 2nd/3rd grade)

These special educators also indicated that inclusion had made them aware of the individual needs and differences of the students. As one special educator for a 5th grader stated, "you just have to be aware of children's abilities and disabilities and what they can do and what they need." Another special educator for the 5th grade added, "It's really hard to break apart and realize you're dealing with a child who has special needs and all you're seeing at some point is the behavior problems. You have to look beyond that." Still another special educator in grade 5 talked about acknowledging individual differences and how this had affected her teaching style.

> *Well, I think when you work with all types of students, because ultimately you do anyway. You have a high-low range. I think it helps to keep you [a] little bit on your toes, open up to new learning styles, different teaching styles which I think is something that you can fall easily into 'I do it this way' mold, so I think they kind of keep us on our toes. I think it's just really, really being aware of different learning styles and what people have to offer. And being able to look at, maybe not the surface, but being able to look a little deeper sometimes to find out that that's special.*

Inclusion also facilitated an increase in professional expertise and perhaps even some personal growth within these educators. As a second grade special educator commented:

> *Well, I think it's been pretty positive because for me, as a special educator, I get to go into the classrooms. It gives me a chance. I'm not as isolated. The kids aren't isolated. So I think it allows for more inclusion not only for the students but for special educators. I think it's good because I get to see all kids at all levels not only kids with special needs, but I get to see them in places with kids who are identified or not special needs kids.*

Another 2nd grade teacher also commented on this area.

> *Specifically as a special educator, inclusion helps me to get into the regular classroom and not be in the resource room and not to have special education be a separate part from the regular education.*

A 3rd grade special educator also talked about how inclusion has affected her both personally and professionally.

> *I think it's really strengthened me in a lot of ways. I think that my philosophy as well as the school's is that all children be served in the regular setting, and I think that it has really enhanced my teaching personally in working really closely with the children and the team*

> *on strategies and how to keep that child within the regular setting.*

Only one special educator addressed the negative effects that she experienced as a result of the full inclusion of students with more challenging emotional needs.

> *I think it's hard because it's hard scheduling-wise. I think it's really hard on teachers when you include special needs kids so much in the mainstream as we do here. From my perspective, it's hard to know what teachers need as far as support goes. To find the time to communicate, to have them communicate to me or for me to get in there and give them what they need. And I guess I know that there's a lot of behind the scenes work that gets done. I don't think everybody always knows about it either. So communicating that - what's actually happening, like things might seem like they are standing still when it's really not. And how long all of it actually takes. It's a long process.* (special educator in 2nd grade)

Discussion

Based on these results, the majority of special educators reported positive effects of inclusion. Among the themes which emerged were increased opportunities to work cooperatively with general educators, professional expertise in working with students with various educational needs, and the ability to appreciate individual differences within these children. The only negative effect expressed by one special educator was the lack of time to consult and communicate with other teachers in order to effectively serve these children within the integrated setting.

The positive effects of inclusion reported by the special education teachers in this study appear to be consistent with what has been found in the literature with respect to the benefits of a unified educational system such as working collaboratively with regular educators and appreciating the individual differences within students. Furthermore, the negative effect mentioned did not pertain directly to the child with EBD per se, but rather to the inclusion process.

Interestingly, the responses from these special educators would seem counterintuitive to what might be expected, given that having "special education" children within the regular classroom setting would suggest that special educators might relinquish some of their roles to the general educators. Perhaps the positive responses are related to these instructors' having been in an integrated setting for a period of time. Nevertheless, the results seem to support the closing gap between general and special educators, and consolidating the educational system.

Overall, it would seem as though inclusion of children with EBD is beneficial for special education teachers. However, it should be noted that these are preliminary findings. Further research is needed using a larger sample of special educators to determine if these perceptions are consistent. Other areas that should also be examined include the characteristics (e.g., structure, composition of personnel/faculty, supportive services) of the particular schools, as well as the impact and/or level of family and interagency collaboration that are available for the special educators.

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Perceptions of Students Experiencing Emotional Behavioral Disorders and Their Peers Regarding Inclusive Classrooms

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This study provides preliminary descriptive data regarding the inclusion of students experiencing emotional behavioral disorders (EBD) in regular classrooms. The results are based on interviews with nine students (second through eighth grade) experiencing EBD and twenty-eight of their peers. This is one part of a larger study that investigated perceptions of parents, teachers and students regarding inclusive education. A qualitative analysis of the data revealed two counterintuitive findings. The first was that students did not contrast and compare heterogeneous versus homogeneous classroom experiences because they had always been educated in inclusive classrooms. The second finding was that descriptions of students experiencing emotional difficulties did not typically include their classmates who were labeled EBD. In addition, three themes emerged from the data regarding the ways in which the participants solve problems, cope with challenging situations, and express a desire to help others. A rationale is provided for how these themes may be influenced by participation in inclusive classrooms and for the inclusion of students experiencing EBD in regular education settings

Introduction

Over the past decade, the literature regarding the inclusion of all students in regular classrooms has predominantly focused on full inclusion of students experiencing mild to severe physical and cognitive disabilities (Giangreco & Putnam, 1991; Stainback & Stainback, 1984). As the successful campaign for the inclusion of students with severe disabilities moves forward, students labeled with serious emotional disturbance or emotional behavioral disorders (EBD) continue to face barriers to full integration. Despite reports of the positive impact of inclusion on teachers and students with and without physical and cognitive disabilities (Giangreco, Dennis, Cloninger, Edelman, & Schattman, 1992; Gartner & Lipsky, 1987), breaking down the barriers between segregated and regular classrooms has been questioned for students with EBD (Braaten, Kauffman, Braaten, Polsgrove, & Nelson, 1988). While there are relatively few studies evaluating the impact of including students with EBD, there is some research demonstrating successful outcomes for students with EBD receiving their education in typical classrooms (Fox, Hamilton, & Broer, 1991).

One of the common fears confronting advocates of full inclusion is the impact of inclusion of students with EBD on the other students in the classroom. In order to address this question researchers need to evaluate outcomes for non-disabled peers as well as for students with EBD. In this regard, when students with and without disabilities are provided opportunities to participate in cross-age tutoring (Schrader & Valus, 1990; Top & Osguthorpe, 1987), buddy systems (Goodman, Powell, & Burke, 1989), cooperative learning groups with students of differing abilities (Slavin, Leavey, & Madden, 1984), and peer mediation (Johnson, Johnson, Dudley, & Burnett, 1992), the outcomes have been positive for all those involved. With respect to cooperative learning the reported benefits include increased achievement, self-confidence and friendships (Slavin, Leavey, & Madden, 1984). The outcome data for peer tutoring has demonstrated enhanced self-esteem and awareness of the needs of others and reinforcement of pre-learned skills (Osguthorpe, Eiserman, Shisler, & Top, 1984, 1985a, 1985b). However, it is important to note that the research above referred to the interaction of students with physical and cognitive disabilities and their non-disabled peers. None of these studies have evaluated the effects of these strategies when used as teachings tools for including students with EBD.

The purpose of this study is to gain an understanding of the ways in which inclusive education effects students with EBD and their peers. Peers, better than anyone else, can describe how going to school with classmates with EBD impacts on their school experience. Regular educators report that listening to the suggestions of their typical students enabled them to identify and implement effective strategies for including students with visual and hearing impairments (Giangreco et al., 1992). In addition, listening to the perceptions of students may enable educators to adapt strategies such as peer tutoring, cooperative learning, peer mediation, and buddy systems to facilitate the inclusion of students experiencing EBD.

Methods

Participant Selection

Participants in this study were 9 students with EBD (7 males and 2 females) and 28 of their classmates (16 females and 12 males). The criteria for EBD was the Federal definition of severe disabilities and serious emotional disturbance (Individuals with Disabilities Education Act of 1990, P.L. 101-476), or Vermont's Act 264 definition of severe emotional disturbance (Vermont Act 264 of 1988). On the Child Behavior Checklist (Achenbach, 1988), a global measure of child behavior problems, the target students were rated by parents and teachers as demonstrating behavioral difficulties above the 98th percentile, as compared to age-matched peers. All of the students attended general education classes at their local elementary and middle schools grades two through eight. These schools were participating in a federally funded project receiving technical assistance to develop model programs for educating children and youth with EBD within regular education settings (Fox, 1991).

Initial contact with the parents of the target students was made by school personnel. Parents and students were provided with a description of the study, copies of all evaluation protocols, and given an opportunity to meet with the project director of the grant prior to giving consent to participation in the project.

Data Collection Procedures

Data were collected by one of five researchers. Each student was interviewed in person on two occasions for approximately 20 to 30 minutes. The interview protocols used a semi-structured format to allow the researcher to accommodate respondents with a wide range of cognitive and verbal abilities. At times the interviews were highly focused to facilitate understanding for younger participants. However, it is important to note that all of the interviewers used a flexible format which enabled the researchers to explore, probe and ask follow-up questions as needed.

The interviews were tape recorded with the permission of the informants and their legal guardian and then were transcribed.

Data Analysis Procedures

Analysis of the transcripts was done by two researchers. A sample list of 20 codes was generated after an initial round of both researchers reading the same interviews. Next, the researchers continued to independently code portions of the data from the same interviews. After 9 rounds of coding and subsequent feedback discussions, 35 codes were agreed upon. Each of the interviews was then recorded by one researcher.

Ethnograph (Seidel, Kjolseth, & Seymour, 1985, 1988), a computer sorting program, was used to sort the text by code. This program allowed the researchers to read what all the respondents said in regard to each code. Reading the data by code enabled the researchers to identify additional themes which included similar and opposing points of view. For example, further analysis of the data coded "how students cope with challenging situations" enabled 5 sub-themes to emerge. These sub-themes were described in memos highlighting contrasting points of view.

Results

Separate data analyses of the perceptions voiced by students with EBD and students without EBD revealed that comments from the two groups were typically indistinguishable from each other. That is, the thoughts and feelings stated by students with EBD were similar to those voiced by their non-disabled peers. In addition, it is important to note that when peers were asked to identify classmates with emotional difficulties, they did not typically mention the students labeled as having a serious emotional disturbance by educators (or students identified as target students participating in this study). For these reasons we have opted to analyze the data generated by the target students simultaneously with peer data.

Three themes emerged from the data: 1) how students solve problems, 2) how students cope with challenging situations, and 3) students' desires to help others. The following is a description of each of the three themes, including sub-themes associated with each theme and supporting quotations. Each student quoted will be identified by grade level and referred to as a target student (students with EBD) or peer (student without EBD).

How Students Solve Problems

> *Well, I've got one friend that's my best friend in my class. His name is Adam (target student) and he's always nice to me. If some kids are, you know, threaten to beat me up, he stays with me and helps me, you know, runs around and stuff to get away from them. He helps me to watch out for them.* (Anthony, third grade peer)

Students described seven different ways in which they try to resolve problematic situations: (a) discuss the problem with those involved, (b) fight back, (c) ask an adult for help, (d) leave the immediate situation, (e) ignore the people involved, (f) ask a friend to go get an adult, and (g) wait for a friend to tell them what to do. Frequently, initial reactions from students are to rely on adults and peers to intervene when they are faced with a dilemma. Students mentioned looking toward their friends, their mothers, a favorite teacher and occasionally a grandparent to provide comfort and solutions.

Often students choose strategies based on their immediate assessment of the level of seriousness of the problem and their desire and ability to resolve the dilemma on their own. A fifth grade target student described it in this way, "Well, when they're being high-strung you ignore them usually. But then sometimes you'll just kinda look at them and see what they're doing and you know they shouldn't do that, so you let the teacher handle it." In contrast to ignoring the problem and/or telling an adult, Sally, a third grade peer, tries to resolve situations on her own.

> *First I try to talk it out, but if it makes me really mad and they keep doing it and doing it and doing it, especially punching me and kicking me, I don't usually use this but, I have to give it back to them sometimes.*

Interestingly, students may rely on their friends to help them recognize when they need support and to aid in seeking assistance from an adult. Paul, an eighth grade target student, said, "Either I deck them or someone in my circle will say 'chill out' or something." Although the option of hitting as a way to solve problems was mentioned by Paul and many other students (including peers), sometimes they rely on a cue from a friend to keep it together. Jonathan, a 5th grade target student, said, "Kids tell me how I could stay out of trouble." One of Jonathan's peers stated "I guess if they're your friends you try to tell them, 'Well, you really shouldn't act that way.'" In some cases students know what to do but are reluctant to act. Alex, an eighth grade target student, stated that, "Sometimes I'll go to a friend and say, 'Could you do me a favor and go tell that kid to please knock it off, stop annoying me?'" As students gain experience and confidence at problem solving on their own they recognize that the responsibility for supporting their fellow classmates is shared by everyone in the classroom. Erica, a third grade peer, described her perception of community among her classmates, whom she feels should share the responsibility for taking care of one another.

> *Sometimes I say to the teacher maybe sometimes we could go over and help them. Sometimes if they're having a bad day and stuff we could help them out instead, so the teacher doesn't have to do all that stuff. We should try and help them because she can't do everything.*

How Students Cope with Challenging Situations

> *I would say to somebody, if you were sad about something or the teacher yelled at you and you were unhappy, then somebody that was a good friend or one of your classmates can talk to you and just be your friend and be nice to you, and just kinda help you through that.* (Elizabeth, 5th grade peer)

Students with and without emotional difficulties shared a multiplicity of suggestions about what they do to feel better when faced with challenging situations. Five global themes emerged from their recommendations: (a) ways to relax or ignore the problem, (b) activities to discharge energy, (c) the need for support from peers, (d) the presence of an adult who represents safety, and (e) what students are telling themselves when coping with difficulties. Overall, typical students continue to respond in ways that are similar and at times identical to strategies recommended by students experiencing emotional difficulties.

When Jimmy, a fifth grade target student, is faced with a challenging interaction with his teacher he says, "I just ignore her. I ignore her lots (and) the things she says to me." One of Jimmy's classmates stated, "Well I close my eyes for a minute and lay my head down on my desk; it just makes me feel better." Susan, a high school, peer said, "Sometimes if I just read, that calms me down." While some students reported consistently relying on one type of coping strategy, other students opted for a variety of very different activities. Paul recommends, "listen to music, draw, skateboard, kick and stomp and just blow out your steam. Sometimes talk to people." Some other active suggestions included "running around a field by myself" and "riding my dirt bike or snowmobile". Jody, a second grade peer, offered the following example.

> *I have boxing gloves that I can use. And I can get punching with my bare hands. I do something to get my mind*

> *off stuff. I play basketball, I play football, I box with other people. I like to be active.*

Several peers were able to recognize when it is safe to offer support and when it is better to wait. "Sometimes I try to help them. Sometimes if they're real mad and I think they might hurt me, I just stay away from them and ignore." However, ignoring people and situations can lead to isolation in the absence of other options. Brett, a second grade peer, appreciates Carol's positive characteristics but avoids her because it is his only way of dealing with her disruptive behavior. He stated, "Well one thing I think about Carol is she is gentle if you don't get her mad and nice and stuff. So I try to keep away from her so I don't get that trouble, you know."

In addition to identifying the variety of options proposed by some students, a pattern emerged regarding the order of those suggestions. For example, if talking to someone (either a friend, a teacher, the principal or their mother) was mentioned it was typically at the end of a student's list of suggestions. Conversely, students reported preferred activities that involved relaxing or becoming more active as a primary option.

Finally, some students openly encourage themselves when they are in the process of dealing with stressful situations. For example, Tammy, a second grade target student, was unable to specifically state what she does to cope with difficult times but she shared what she is thinking when trying to cope. "I try not to get mad at myself. I control my mind."

A Student's Desire to Help Others

An overarching theme of what students value is having the opportunity to help someone. Regardless of age, gender or ability, most students expressed an interest in helping out a classmate or teacher.

> Paul, an eighth grade target student, pondered, *I keep most of the people in my circle out of trouble. Then usually I get into trouble for them. If someone needs help doing homework or something, I'll help them with it. Teachers need stuff moved, I'll move it.*

In addition to wanting to help out, students are able to assess what they need to do to meet a classmate's needs. Samantha, a 5th grade peer said,

> *Well, if it is Susan, I'd buy her a stuffed cat because she loves cats. It really depends on what they like. If they had a problem in school, I'd help out. If they are stuck on a problem, in say Math, and they called me after school, I'd talk it through with them, if I understood it. (But) I wouldn't tell them the answer, because that would be cheating.*

One way students help each other is by showing their appreciation of a person's contribution to the class. As one fifth grade peer described,

> *Like I said, you could say, "that was a great shot, you're doing real good. "Some of the kids that were really bad when they first started, they're really good now. You could say, "You really improved a lot and stuff."*

In contrast, some older students felt that it was embarrassing to give and or receive compliments. Carrie, an eighth grade peer, suggested, "Well, if it's a joke , laugh with them or something like that. But I wouldn't just go up to someone, (and say), 'Thanks for making me feel good.' "There were a number of peers who focused their comments about helping others on descriptions of assisting students who experience some emotional difficulties. One eighth grade peer explained,

> *It's hard, because it slows us down. Because, he's like, "How do you do this, how do you do that?" And it's like you've got to get your work done and you get frustrated but we don't say, "You're so dumb or anything," we just like say, "Okay, what you do is you got this number right here and then you multiply it by this." So we say, "Push this button."...I don't give him the answer*

> *because it doesn't help him learn. I say, "Okay what did you get for an answer?" And then I compare it with mine and if it's right, it's right. If it's wrong I just explain what he did. So its kind of frustrating though, working with him. You want to get your work done but then you can't tell him he's stupid and you can't go past him or anything, so its awkward. But I don't mind because I like teaching people, I think its fun.*

Finally, Peter described the support he receives from a friend in this way, "I got another friend, he's my best friend, George, and he always talks to me in a calm way and helps me with my work and stuff."

Discussion

In trying to understand the effects of inclusive education we listened to the words of students. Both students with and without EBD were provided with opportunities to describe their experiences as members of inclusive classrooms. In this regard, their thoughts and feelings generated multiple themes about the ways in which participating in inclusive school communities has influenced their educational experience. Since most of the students have always been in classrooms heterogeneously grouped, they did not compare and contrast heterogeneous grouping with homogeneous grouping. Even though they did not specifically attribute their experiences to being in inclusive classrooms, the processes they described for solving problems, coping with challenging situations and a desire to help others may be dependent upon interacting in heterogeneous classrooms.

Students reported numerous strategies for solving problems and coping with difficult situations. Those strategies engaged in by the target children were similar to those used by their peers (i.e., soliciting advise from a friend about what to do differently, relying on a friend to tell you when to act differently and to go to an adult for help). Students with EBD were able to learn from their peers by observing them discuss problems, respond by ignoring, or leave difficult situations and ask adults for assistance. Peers demonstrated appropriate options for how to respond to different situations as well as determining where and when those options are applicable.

In addition to peers modeling appropriate behaviors and assisting the target students, classmates expressed receiving benefits from inclusion. For example, peers described an ability to recognize the needs of other classmates and a willingness to provide support, guidance and assistance. Peers admitted that at times it is challenging to work and interact with students with differing abilities, but that they enjoyed teaching and helping others. Furthermore, it is important to acknowledge that the reportedly difficult students were typically not the target students. By listening to students with and without EBD we can recognize what types of interactions are difficult and look for ways to refine their ability to cope. Knowing what to tolerate and when, practicing how to give and receive support, and being able to mediate without adult involvement are all social skills that are needed to foster healthy relationships with a variety of individuals in childhood and adulthood. Developing friendships and positive working relationships with people who are different is an important prerequisite to educating citizens of diverse communities.

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Perceptions of Regular Educators Regarding the Inclusion of Students with Emotional Behavior Disorders

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The purpose of this study was to describe the experiences of general education teachers who have included a student with emotional behavioral disorders (EBD) in their regular education classes. The study reports preliminary data from interviews given at two points during the school year with ten general education teachers, second through eighth grade. A qualitative analysis of the data was conducted using categorical coding procedures to identify themes related to the teachers' experiences. One of the central themes that emerged was the personal and professional impact of inclusion on teachers. The results indicated that most of the regular educators identified some positive gains, personal or professional, from the experience of including a student with EBD in their regular education classes. Furthermore, their perceptions did not change between interviews and were not dependent on years of experience teaching, knowledge of special education, or having additional support and courses specific to including students with EBD in the regular classroom environment.

Introduction

The term "inclusion" has been interpreted in many ways. For the purpose of this study, inclusion is defined as "the process of systematically bringing together children with disabilities (regardless of the nature or severity of the disability) and typical children of the same age, in natural environments where children learn and play" (Erwin, 1993). Within the school environment, this includes: placing the student with age appropriate peers; providing educational support based on the student's individual needs; and placing the student in a regular education class with the necessary supports or services to assure success in that environment.

The appropriateness of general education class placement for all students has been debated nationally (Giangreco, Dennis, Cloninger, Edelman, & Schattman, 1992). The ongoing debate, has generated considerable support for regular education placement (Gartner & Lipsky, 1987; Reynolds, Wang & Walberg, 1987; Will, 1986), even for students with more severe disabilities (i.e., severe physical needs, profound learning impairment) (Giangreco & Putnam, 1991; Lipsky & Gartner, 1989; Stainback & Stainback, 1991; Thousand & Villa, 1990; Villa, Thousand, Stainback, & Stainback, 1992). Despite this growing support, the appropriateness of placing students with serious emotional disturbance or emotional behavioral disorders (EBD) in the general education classroom continues to be questioned

(Braaten, Kauffman, Braaten, Polsgrove, & Nelson, 1988).

The state of Vermont has made a commitment to serve all students in regular classes in their local schools. In 1990 the Vermont legislature enacted Act 230 (Vermont Act 230 of 1990) which directed each school district, in consultation with parents, to design and implement a comprehensive system of educational services to assure the success of all students in regular classrooms. Most school districts in Vermont now offer integrated educational programs, and many fully include their students with disabilities in general education placements (Giangreco, et al., 1992). However, even though some schools have successfully included their students with EBD within the general education classroom since as early as 1984 (Fox, Hamilton, & Broer, 1991), inclusion of students with this specific disability continues to be challenged.

An educator's understanding of and attitudes toward children with disabilities has been perceived as "influential in determining the intellectual, social, and emotional adjustment" (Jamieson, 1984, p. 211) of children with disabilities. Consequently, the knowledge and attitudes of general educators toward mainstreaming students with disabilities has been investigated extensively (Jamieson, 1984). However, the data from these studies often have yielded conflicting information and been difficult to interpret. Furthermore, the data often have been collected from paper and pencil tests as a sole measure, or the studies have focused on the experiences of educators who did not have primary responsibility for educating the student.

The current study was designed to allow regular educators to speak from their own frames of reference regarding the experience of having students with EBD in their classrooms. In all cases, the student was on the regular educator's class list and was considered part of the class, the regular educator was responsible for designing and implementing most of the student's educational programs as part of the student's educational team, and the student spent all or most of the school day in the regular classroom with the regular educator.

Methods

Subjects

The participants in this study were ten general education teachers who worked in seven Vermont public schools teaching second through eighth grade. Teachers were selected to be interviewed based on the following criteria: (a) during the last year all had a student with EBD in their general education classrooms on a full-time basis; (b) the students met the Federal definition for eligibility for special education services under the category "severe disabilities and serious emotional disturbance" (Individuals with Disabilities Education Act of 1990, P.L. 100-476) or Vermont's Act 264 definition (Vermont Act 264 of 1988); and (c) the students were part of a federally funded project (Fox, 1991) to provide statewide training and technical assistance to educational teams serving students with emotional behavioral disorders in the regular classroom.

Six male and four female teachers were interviewed. Their teaching experience ranged from three to more than twenty years. All were certified in general education; none had special education certification. Only one of the teachers reported receiving inservice training designed to prepare him or her for including a student with EBD in a general education classroom during the three years preceding the student's placement. Four of the teachers had at least part-time paraprofessional support (e.g., instructional assistant, one-to-one aide, teacher's aide) assigned to their classroom. All ten teachers had access to ongoing support from district or regional special educators and related service personnel (e.g., guidance counselors, school psychologist, speech/language pathologists, integration specialists).

Data Collection Method

A semi-structured interview was selected as the primary method for data collection because it provided the teachers an open-ended format to share their experiences and gave the interviewer the opportunity to ask follow-up questions. The interview protocol allowed for the initial set of questions to be presented in a non-standardized way or in a different order, so that each interviewer could individualize question-asking. Teachers were asked the same questions in a follow-up interview, thus providing the opportunity to explore changes in perceptions across the school year.

All teachers provided written consent prior to being interviewed regarding their experiences teaching a student with EBD in the general education classroom and agreed to be interviewed at two points during the school year. Interviews were conducted between November 1991 and June 1992 in private rooms located at the schools where the teachers worked. Each interview was tape recorded with teacher permission. Interviews ranged from 30 to 60 minutes.

Each interview began with a review of the purposes of the research, an explanation of confidentiality and that all participation was strictly voluntary. The interviewer collected general background information about each teacher through administration of a survey prior to asking all questions on the interview protocol. At the conclusion of each interview, the interviewer asked each teacher if there were any questions or further comments.

Data Analysis Procedures

Analysis of interview data consisted of categorical coding. A total of 35 codes (e.g. description of student, impact of inclusion) were developed to describe portions of text. After the initial coding of all interviews, each interview transcript was re-coded by adding, combining, or separating previously coded text. These subsequent codes assisted in identifying emerging themes in the data.

Given the volume of interview data, a text sorting program (Seidel, Kjolseth, & Seymour, 1985, 1988) was used to sort the data by the 35 categories identified. This program assisted with the identification of themes and sub-themes that could be considered for analysis. Once themes were identified, positive, neutral or negative occurrences were highlighted and organized to assist in understanding the interview data. These sequenced themes were reviewed by the research team to ensure that the analysis was consistent with and/or not contradictory to their interview experiences with the teacher.

Member Checks

In April of 1993, a report about the results of analysis from the interview data was sent to all ten teachers. Using a member check protocol similar to that developed by Giangreco et al. (1992), all the teachers were asked to read the report and answer the following questions: (1) Are you satisfied that your anonymity was maintained in that the information you provided us is not personally identifiable? (2) Did you find that the content of the report accurately presented the information you provided in your interview? (3) Do the themes presented in this report include information you gave us in the interview? and (4) If quotes from your interview were used in this report, did you feel they were presented accurately and appropriately? A space was also available for the teachers to make any additional comments that might help the researchers more fully understand their perspectives. Teachers returned their member check forms in self-addressed stamped envelopes. Teachers who did not return their forms within two weeks were contacted by phone and asked to respond verbally to the member check questions. Teacher responses were used to adjust the final presentation of the study.

Results

As part of the interview protocol, all of the educators were asked what effect inclusion had on them professionally and personally. Their responses focused on the following areas: quality of education for the student; awareness of individual student differences and needs; awareness of the needs of all students; patience; workload and stress; and style of teaching. When the responses from the two interview sessions with each teacher were compared, it was found that the educators' perceptions did not change.

In terms of educational quality, one elementary teacher felt that the experience had changed his belief that some children get a better education outside the regular classroom. That elementary teacher said, "I believe strongly that every kid should be in the classes. At one time I thought they probably would get a better education if they were taken out of the class...But now I feel that being in the class, socially they're just doing so much that I believe the social takes over the academic."

Some of the educators thought the experience had increased their awareness of individual differences in the classroom and the need to accommodate for these differences. One fifth grade teacher commented that, "It has clearly made me aware of children with different needs. Especially focusing on a traditional school program that I'm well versed in, my education, really, was a very traditional model. What I was taught as a teacher was a much more traditional model. And to really learn that there are children such as J., and other children, that need different ways of being taught. They do not always function in a traditional setting. And, they're bringing a lot of different things in. My values and my background are different than what his background and his values are, and I cannot force my values and my background upon this kid, and I have to change some of my own thinking." Another educator said, "It certainly has made me, just recently, more aware of each person's individual needs. And also, the way I teach, which used to be more of a whole group, and now having to deal individually with individual learning styles is totally different...." A second fifth grade teacher said, "Well, it's forced me to look at the way I present my material. Not to try to just teach to the middle. A lot of times, right now it's forcing me to work a little harder. There's some materials that are good for some kids and some that aren't. Sometimes you have to adjust your materials. It's forcing me to use other methods to get it across. Like all out cooperative learning, a lot more group work. I think just the way I present the material and my focus has been a lot different." Still another fifth grade teacher in a different school added, "At first I think I was frustrated because I wanted all children on the same level. So If Johnny got a 'B' I expected the same goal for Johnny that I would for Mary. I don't do that anymore. And that's like if, you know, on an essay question, Johnny may not be able to write so he has to tell me things and I used to say, 'No, you've got to write it down'. I don't do that anymore."

Other educators said that it had heightened their awareness of the needs of the other children. An elementary school teacher addressed the need to recognize and reinforce all students who do a good job. "I try to make sure that any reward system that I do is something that's available for all students. For one, it singles out that one student and for two I don't believe in a system that rewards a student that's occasionally okay, and the other kids that do a good job don't ever get rewarded. It's made me much more aware of the kids who are very capable functioning in a regular classroom, it's made me much more aware of rewards for them." Another educator added, "It's made me more aware of everybody's needs. And how my reaction to certain situations effects things at any one time. Probably made me more aware. I would like to think that it's given me more patience."

Another elementary school teacher talked about gaining patience, "I hope it's made me a little bit more patient. I find that I have to be much more tolerant of things that I would never foresee myself, or for other children doing." In addition he said, "Both good and bad. There is a lot of tension because of it, because of dealing with some of the unpredictability. I would say that that is the biggest draw back, the unpredictability. The good part is when you do develop the rapport and things do go well its a real exciting feeling. I hope to say that it's made me a more patient person."

One junior high school teacher talked about the amount of work and stress which was involved, "It's increased the workload. Increased personal and professional stress. Increased parent contact, both good and bad... well, I think you have to develop creative strategies to deal with these students in the classroom. It's on the responsibility of the classroom teacher to do that. There aren't tremendous resources available and you're very challenged behaviorally and academically to keep these students in the ballgame. It's also helped me form opinions as to who I feel does belong in the classroom, what types of students can be integrated, which ones can't."

A middle school teacher also alluded to the increased stress, "I just think it's something new I'm learning that I've not had experience before in my life. I just think of that. I can't get it out of my mind. You know, you go home, you don't relax when you've had a day like this. It's hard to relax. I think it would effect most anyone like this. It's something you don't forget. I just try to get out and go for a walk or a jog or ride my bicycle." She also said, "We're closer now. It takes time, it's a lot of work."

Still others thought it hadn't changed them or their style of teaching because children with challenging behaviors have always been part of their classes. One junior high school teacher commented, "It hasn't changed me any more than in the past. What did change was the fact that he had an aide with him and that eliminated a lot of the extra time he would have taken that I was able to divvy up amongst the rest of the children. I've had children that require a great deal of attention at different times so its no different for me. Except now I have an aide, which is nice."

Discussion

This study has described the experiences of general education teachers in regard to the placement of students with emotional behavioral disorders in their regular classroom. The interviews described in this study offer preliminary support for the inclusion of students with EBD in general education classrooms. However, given the small number of participants and limited settings, these results cannot be generalized beyond those settings. Nevertheless, the preliminary findings raise some interesting questions for future study.

Seven of the ten educators who participated in this study indicated primarily positive to neutral experiences and outcomes with the inclusion of students with EBD in their regular classrooms. Three of the educators expressed more negative feelings and experiences. Interestingly, the educators who participated in this study all maintained their initial perceptions about the inclusion of students with EBD between the two interviews. For example, those who felt more negative about the experience during the first interview, maintained those perceptions in the second interview five to six months later.

At two of the sites where an educator expressed more negative perceptions about the inclusion of a student with EBD, a second educator also participated in two interviews. Despite referring to the same student and teaching in the same grade level in the same school building, the second educator at both of these sites expressed notably positive perceptions and experiences related to inclusion of the same student. This outcome leads to speculation about the types of attitudes, beliefs and values of the educator that are predictive of more successful placement and acceptance of students with emotional behavioral disorders in general education classrooms.

At the three sites where negative perceptions were emphasized about inclusion of the student, none of the students were identified as eligible for special education through having serious emotional disturbance. However, all three met Vermont's broad mental health definition (Vermont Act 264 of 1988) for severe emotional disturbance. Furthermore, none of these students received special education services or supports. Therefore, these more negative perceptions were actually in response to the regular educator's experience working with non-special education students who presented challenges within the classroom. This raises concern about several possible issues that need further exploration: under-identification of students who should be eligible for special education; needed training for teachers in general class management skills; supports needed by teachers to address the issues of all students; and legal supports for students who are challenging, but are not part of special education.

Those educators expressing positive, neutral, or negative perceptions included new teachers as well as experienced teachers with more than 20 years in the classroom. None of the educators had certificates in special education and only one educator had a course specifically about students with serious emotional disturbance. For the limited number of regular educators included in this study, a successful experience including students with EBD did not depend on years of experience, knowledge of special education, additional resources or specific education in regard to inclusion of students with this disability.

The perspectives described by the teachers in this study are important because only a few general educators have had the experience of: being the primary educator responsible for the education program of students with EBD; having students with EBD on their class list; and fully including students with EBD in their regular classroom environments. Too often the decision about placement of these students precludes inclusion within the regular classroom. Too often this decision is based on the myth that students with this disability cannot be placed in the regular classroom. Hopefully some of the experiences of these educators who actually have these students in their classroom will challenge the belief that children and adolescents with this type of disability can only be educated in segregated classroom settings.

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Perceptions of Parents Regarding Their Involvement and Experience with Collaborative Educational Teams for Students with Emotional Behavior Disorders

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The movement toward educating all students (including those with severe disabilities) within the regular classroom, has necessitated changes in the philosophy and structure of the school system. Collaborative teaming, a non-hierarchical group decision-making process, has been advocated as an effective model for assisting schools in this process of full inclusion. This study explored the perspectives of parents with children experiencing emotional behavior disorders (EBD) with respect to their involvement and satisfaction with collaborative educational teams. Semi-structured interviews were conducted at the beginning and end of the school year with 11 parents of 9 students with EBD. Students were in grades 2 through 8, representing a range of school districts throughout the state of Vermont. A qualitative analysis of the data indicated that parents differed in their degree of involvement with the collaborative educational teams for their children, although a majority reported feeling like full team members. All of the parents who perceived themselves as full team members, with an equal voice in decision-making, felt positively about the teaming process and believed that it had a beneficial impact on the education of their child. Thus, this study provides preliminary support for the inclusion of parents as full members on educational teams. The specific benefits of the team process for parents and the implications for the educational system are discussed.

Introduction

During the past 20 years federal legislation has mandated that all students be educated within the least restrictive environment. While this has enabled students with disabilities to attend local public schools, many have continued to be segregated from their peers by receiving extensive "pull-out" services and being placed in resource room settings (Villa, Thousand, Paolucci-Whitcomb, & Nevin; 1990). Recently, there has been a move towards a model of full inclusion, whereby students of varying needs are placed in the regular classroom with supportive services as needed (Gartner & Lipsky, 1987). This change in educational model has brought about associated changes in the needs of the school system. As stated by Villa et al. (1990), "We believe that the current momentum to actualize the philosophy of inclusive education for all students inevitably leads to a paradigm shift related to the organizational structure of schools (p. 284)."

Currently, many schools have implemented a model of collaborative teaming in order to plan for the individual and diverse needs of students being educated within regular classrooms. The collaborative teaming model utilizes a group decision-making process whereby individuals with varied skills work together to achieve mutually agreed upon goals. There is an underlying assumption that all members of the group are equally valued and can make unique contributions. In contrast to hierarchical groups, collaborative teams rotate and share roles (e.g., facilitator, recorder) and there is an equal distribution of tasks. The process involves positive interdependence, open communication, creative problem-solving, individual accountability, and ongoing evaluation of the team's functioning. When it is used in school systems, the collaborative model is designed to facilitate communication within the school, improve home-school and interagency coordination, provide support to school staff, parents, and other persons involved with the student (Johnson, D. & Johnson, F. 1987; Rainforth, York & Macdonald; 1992; Thousand & Villa, 1992).

The efficacy of the collaborative teaming model has been demonstrated across different types of organizational settings (Appley & Winder, 1977; Brandt, 1987; Thousand & Villa, 1992). A meta-analysis of more than 450 studies, conducted by Johnson, D. & Johnson, R. (1987), provided empirical support to indicate that a cooperative organizational structure is associated with increased achievement, better interpersonal relations, increased social support and higher self-esteem among team members, as compared to organizational structures based on competition or individualistic approaches where persons work independently. Specific to school systems, there is descriptive data to suggest that teachers, administrators, and related staff perceive the team process as beneficial (Albano, 1983; Meyer, Eichinger & Parker-Lee, 1987). However, the research literature has systematically ignored the perceptions of parents regarding their involvement on collaborative teams (Giangreco, 1989).

The few studies that have explored parents' perceptions regarding their child's educational needs indicate that parents of students with severe disabilities (i.e., sensory, cognitive, and physical impairments) disagreed with professional retention of authority and wanted to be included in educational decisions that affect their child and family (Giangreco, 1990; Giangreco, Cloninger, Mueller, Yuan, & Ashworth, 1991). There is also evidence to indicate that when parents are involved in their children's educational programs, the children are more successful in school (Salisbury, 1992). Furthermore, federal law (Individuals with Disabilities Act, PL 101-476, 1990) requires that parents be given the opportunity to participate in their child's educational planning. Nevertheless, studies have shown that over half of all Individual Education Plans are completed *prior* to meeting with parents. Research has also shown that parents are treated differently from other members of school teams (i.e., not respected and valued as full team members) (Gartner & Lipsky, 1987; Salisbury, 1992). However, there is a lack of studies regarding the perspectives of parents of children with emotional behavior disorders (EBD) with respect to their education. These parents' perceptions are particularly important given the ongoing controversy regarding the inclusion of students with EBD (Gartner & Lipsky, 1987; Braaten, Kauffman, Braaten, Polsgrove & Nelson, 1988).

The purpose of this study was to explore the perceptions of parents of children with EBD in regard to their experience with collaborative educational teams. This is one part of a larger study on inclusion of students with EBD that assessed the perspectives of parents, regular educators, special educators, and students.

Methods

Participants

The participants for this study were 11 parents of 9 children with emotional behavior disorders (EBD). The criteria for determining EBD was either the Federal definition of severe disabilities and serious emotional disturbance (Individuals with Disabilities Education Act, P.L. 100-476, 1990) or the state of Vermont definition for severe emotional disturbance (Vermont Act 264, 1988). All of these families were involved with a federal grant (Best Practices for Educating Students with Serious Emotional Disturbance in their Local Public Schools and Communities in Rural Settings) designed to provide technical assistance to educational teams serving students with EBD within regular education settings (Fox, 1991). The students attended 9 different public schools throughout the state of Vermont and were enrolled in grades 2 through 8.

A total of 8 mothers and 3 fathers participated in this study (representing 9 families). Six were biological parents, 3 were adoptive parents, and 2 were step-parents. In all but one instance, the child was living with the parent who was interviewed. The exception was one interview which was conducted with the non-custodial parent. However, in this latter case, the parent reported considerable contact with his child. In 3 of the 9 families, there was only one parent living in the home at the time of the interview; although, for one of these 3 families the father was only temporarily absent from the home. Of these 11 respondents, 5 were employed and 6 were not in the labor force.

Procedures

Students and their families were recruited to be part of this study based on the decision of school personnel (i.e., administrators, regular classroom teachers, special educators). Each school was asked to select one student who met the criteria for emotional behavior disorders, as described above. Letters describing the nature and purpose of the study were then sent out to parents by the school. If interested, parents were asked to contact the school and were given the opportunity to discuss the study in more depth with the grant's project director. Prior to the actual protocol, parents were informed of the confidentiality of their responses and were asked to sign a written consent form.

The protocol for this study consisted of a semi-structured interview, Likert scale surveys to assess satisfaction with the school's ability to serve students with disabilities, and the administration of a standardized measure to assess the child's behavior within the school and home settings. However, for the purpose of this report only the qualitative results from the semi-structured interviews will be presented. Parents were asked to describe the experience of having a child integrated within the regular classroom setting. The interview format was flexible enough to enable parents to provide their perspectives from their own frame of reference. Interviews were conducted by a member of the project staff with each parent at the school, within the parent's home, or at another location of the parent's choice. Each interview was tape-recorded and lasted approximately 30-60 minutes. This protocol was administered at two time points: 1) prior to or within three weeks of the formation of individual student planning teams, and 2) at the end of the school year. All interviews were conducted between November 1991 and June 1992. Typically, there was a 5 to 6 month gap between the pre and post interviews.

Data Analysis

Each of the interviews was transcribed and categorically coded, based on 35 thematic areas. These codes were generated by the research team based on the content that emerged from an initial review of the interview data and were not pre-determined. Two researchers independently assigned codes for each transcript. Inter-rater reliability exceeded 80%. *Ethnograph* (Seidel, Kjolseth & Seymour, 1988), a computer sorting program, was then used to sort the interview material by its assigned codes. This process enabled the researcher to review and analyze all of the relevant data pertaining to a particular code and to generate additional thematic categories. For the purpose of this report, the data regarding only one thematic area, collaborative teaming, will be discussed. Because of missing interview data, the pre and post interview data was collapsed, instead of being analyzed separately.

Member Checks

An initial reporting of the results was sent to all 11 parent participants. An accompanying letter asked parents to indicate whether the results protected their anonymity, accurately presented their opinions and quotes, and whether the themes reflected their input. Parents were asked to return these member check forms to the project staff in the self-addressed stamped envelopes. The purpose of the member checks was to increase the reliability of the study and modify the results based on these comments.

Results

With respect to parents' involvement in the team process, the results indicated that parents varied in the degree to which they felt like a full team member, with an equal voice in decision—making. On one end of the continuum were parents who expressed minimal involvement with the teams ("I'd rather done the forms at home than, you know, came in and do it."; "...I haven't heard any bad reports or any good reports. I just haven't heard anything."). At the other extreme, were parents who indicated that they were "most definitely" full team members, with equal say in all decisions regarding their children. "If I can't make a meeting for one reason or other...maybe I've missed one or two...they have sent me copies of the minutes of the meetings so I can keep updated...Yes, I feel like an equal partner." Two parents described having a moderate degree of input. One of these latter parents indicated that she only feels included in the team process "when they want me to be. When it's convenient for me to be...I don't really have a lot of trust in my voice being equal." This parent advocated for schools and parents to "work a little bit more closely together and allow the parent to have a full voice, not a half voice or a tenth of a voice, or three-quarters of a voice. Parents should be able to have a full equal voice in their child's plan and they should be listened to."

All of the parents who described being full team members felt very positive about the teaming process. There were numerous benefits that they associated with this type of collaboration. Several parents described the benefits of increased communication and sharing of information. For example, some parents indicated that by listening to the approaches employed by the teachers, they gained new ideas and skills regarding how to deal with their children's behavior problems. "I learned some things about how to deal with different things that [my son] does and his behavior, because they've been working on his behavior, too." It was also felt that collaboration increased the consistency between the school and home environments.

> *Being kept up to date is how I can be more effective with [my son] on the outside if I know what's going on, when it happens and how it has been dealt with instead of trying to deal with it without knowing and possibly being counter-productive and hurting the work that they are doing.*

Furthermore, the teaming process offers an opportunity for teachers to learn from parents. As suggested by one parent,

> *They should work more with the parents...be willing to listen to the parents' ideas about how to deal with this kid. If this kid has behavioral problems and the regular school program or discipline is not working, the parents may have some creative ideas that may seem unorthodox to schools.*

Another reported benefit of collaborative teaming was that it facilitated the process of making changes in the student's program and making sure that follow through occurred.

> *Last year it was like our heads were up against the wall to try and have the IEP changed or anything else. Like they were just trying to shove him under the rug and get him out of their hair. I mean that's what it seemed like to us. It was easier to suspend him for five days at a time, then to have him in school and try to deal with everything that is going on. This year with the team and everything, it's helped out a lot, it's worked out a lot better.*

This theme was reiterated by another parent who emphasized "the meetings that we've had to ensure that [my son] gets his services in the classroom", when asked to recall any experiences with the school that were extremely positive. In general, parents who were full members felt that it was truly a group effort and that they had equal input into their children's schedules. "Those group meetings...everybody learns what's going on, everybody has input in what's going on." Another parent also compared her positive feelings of involvement to her previous frustrations when not part of a school team.

> *I think it's given me better insight into the teaching processes within the public school system and the ability to voice my opinion about them and about [my son's] problems. I felt in my lifestyle we were bumping our heads against a brick wall before with other school systems where we were allowed to attend certain meetings, but the real crucial ones, we really weren't.*

Perhaps most important, it was suggested that the teaming process had a direct effect in reducing the behavior problems of students and making them feel supported.

> *Since we've had this team together, I'd say that we've come a long way with [my son]. I'd say that he's done a lot better. Last year he was out of school more than he was in school because they would just kind of shove work at him and there's no way he could do it. He was acting out. This time with this team, he knew that we were in contact with everybody every week and it seemed to help him.*

A couple of parents also felt that it was helpful to have the student be included on the team.

> *Even [my son] has input into what's going on, which is good; that way, he doesn't feel that everybody is working behind his back trying to do this against him instead of just trying to help him.*

There were only two parents who reported negative effects of the school teams. One mother who felt excluded by the school expressed her fears of having too many professionals working with her child. "I worry about too many people having different points of views and coming up with their own labels." Another parent who reported minimal involvement stated that she felt too pressured by the school to be part of the team process. "I didn't want to come to the meeting, I didn't want to come, they kept calling me anyway, I said no, I don't want to go to school, I don't want to take [my younger son]. He doesn't go with a baby-sitter, so I'm the only one, he hasn't been away from me since he's been born..." In general, however, most parents felt that the combined effort was advantageous in that "we all worked together to support a common goal."

Discussion

This study provides support for the philosophical position that collaborative teaming is a useful process in developing appropriate educational programs for students with emotional behavior disorders. Furthermore, it underlines the importance of parents being provided the opportunity to be full and equal members of their child's educational team.

The reported advantages of the collaborative model include: 1) increased home-school coordination (i.e., sharing of information, increased consistency across environments), 2) facilitation of changes in the student's educational program and 3) a decrease in the student's behavioral difficulties. However, these positive perceptions are contingent on parents feeling that they are respected and valued members of the team process, with an equal voice in decision-making. Simply having group meetings is clearly not equivalent to a collaborative teaming model. When parents feel that they are "token" members only and are excluded from critical decisions regarding their children, these results suggest that there is a subsequent lack of trust in the school staff and concern regarding multiple perspectives.

Furthermore, while these results confirm the need for parents to be given the opportunity to participate on school teams, it is important that they have the final choice as to their level of involvement. Parents may have numerous reasons (i.e. job conflicts, lack of child care) why they are unable to be involved at a particular point in time and it should not be assumed that this limited involvement reflects a lack of caring regarding their child. However, at the same time, schools must be aware of subtle barriers to parent participation (i.e., devaluing their input, intimidating interactions) and discuss with parents how they can facilitate their participation.

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Studies on Child Welfare/Foster Care Systems

Chapter 5

What Helps and What Hurts: Characteristics of Foster Children, Their Families, and the System of Care Which Affect Appropriate Permanent Placements

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In a federally funded research and demonstration project entitled "Fostering Individualized Assistance Program," (FIAP; also called IST for Individualized Support Team)[1] four clinical case managers (Family Specialists), empowered by federal, state, and local mandates and by wrap-around service checkbooks, began direct, broad-based clinical and related services to 54 randomly assigned foster children with, or at risk of, severe emotional disturbance, in mid-1991. An equivalent group of 78 foster children were randomly assigned (from the same pool) to a "Standard Practice" condition, for research and comparative purposes. Treatment to date has resulted in marked success, both for the children and families served, across most outcome variables. This paper presents the results of a survey of the four Family Specialists after 18 months of service (October, 1992), seeking their data-informed, but unmeasured, professional opinions as to the relative presence and importance of those factors and characteristics found in foster children, the adults in care of, or in service to them, and in the child care system, itself, which either enhance or deter the success of treatment and permanency plans. The findings of this survey are discussed in terms of some likely areas for reform in the system of care for children and families.

Introduction: The Fostering Individualized Assistance Project (FIAP)

In light of preceding research and related literature (Boyd, et al., 1992; Boyd, et al., 1991; Boyd, Struchen & Panacek-Howell, 1989; Boyd, Struchen, & Panacek-Howell, 1990; Clark, & Boyd, 1991; Clark, & Boyd, 1990; Lee, Clark & Boyd, 1993; and Sullivan, Henley, & Williams, 1988), in early 1991, the National Institute of Mental Health, through the Florida Department of Health and Rehabilitative Services (HRS), partially funded a three year study at the University of South Florida meant to demonstrate more effective ways of providing mental health and related services to the most troubled foster children: the FIAP Study.

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[1] Child, Adolescent, and Family Branch of the Substance Abuse, Mental Health Services Administration (Grant ID#: 5 R18 MH47910-03). H. B. Clark & L. A. Boyd, Co-principal Investigators, Dept. of Child and Family Studies, Univ. of South Florida, Tampa, FL 33612. In Kutash, K., Liberton, C. J., & Friedman, R. M. (Eds.) *6th annual research conference proceedings: A system of care for children's mental health: Expanding the research base.* 1993. (in press).

Purpose of the FIAP Study

The purpose of the FIAP study is twofold. Its clinical and systems purpose is to establish an individualized system of care for providing mental health and related services through an ***Individualized Support Team (IST)*** to foster children, ages 7-15 years, who have severe emotional/behavioral disturbances, or are at risk of such. Its research purpose is to conduct a controlled study of the relative efficacy and effectiveness of two treatment systems (i.e., IST Group and Standard Foster Care Practice (SFP) Group) in achieving permanency, preventing regressive placements, and improving emotional and behavioral adjustment, school attendance, and academic performance of the children, which comprise the study's major dependent (outcome) measurement categories.

SFP Group. This group of children accessed whatever services are typically available within the foster care system, as it currently exists.

IST Group. The IST intervention integrated such individualized, mental health and related services as are needed by each of its assigned foster children and their families, and wrapped those services around them, unconditionally, including:

1. strength and need-based assessment of each foster child and family;
2. interdisciplinary team development of individualized service plans;
3. intensive case management of each service plan;
4. flexibly funded, family centered, home and community-based services;
5. enhanced permanency planning; and
6. providing, brokering and facilitating modified or additional services, as needed, to enhance the success of each integrated service plan.

At the heart of IST are four Family Specialists and their Clinical Supervisor. The Specialists served as intensive therapeutic case managers, collaborating with foster care counselors, foster parents, natural and adoptive families, and other professionals, and integrating treatment efforts around each child and family service plan. Specialists followed and served their assigned children across all settings, providing continuity and wrapping services around them, as needed.

Family Specialists worked directly with most individuals providing services to their case loads of about 13 such children, each, in order to: re-address and enhance their permanency plans, reduce the number of their residential re-placements, improve both their behavioral and emotional functioning, and shorten their lengths of stay. Special emphasis was placed on working directly with both biological and foster parents, foster counselors, teachers, etc., most of whom were constituted into interdisciplinary teams for each child.

Project purchased services included respite care, a variety of therapeutic interventions, and a wide array of wrap-around recreational and other services for clients and caretakers, all meant to enhance treatment effects. Additionally, cornerstone and constant advocacy with and through those with significant influence on these children and their families was practiced. Family Specialists met regularly as a project clinical team with their supervisor to evaluate and trouble shoot cases, service plans, progress, etc. In addition, each Family Specialist kept a comprehensive and detailed Activity Log for each day of service, to afford examination and evaluation of the treatment (independent) variable.

Preliminary Results of the FIAP Study

Recent analyses of the data from the first year of the study reveal both socially and statistically significant comparative results favorable to the IST group. There are no significant differences between the children in the two groups prior to startup of services. The annualized rate of placement changes for the IST children has been reduced, since intervention, in contrast to the SFP Group's relatively constant average placement change rate. Additionally, the comparative results of youth self report on Achenbach's *Child Behavior Checklist* reveal that the IST Group members are experiencing greater improvement in their behavioral/emotional adjustment than the SFP Group, across most subscales.

Anticipated Benefits of the FIAP Study

In order to capitalize on the results and momentum of this study, the authors are seeking ways to further expand the knowledge base in the field, by focusing on additional foster care reform. This reform effort should implement, in the system of care for troubled children and families, the most effective components for serving them and addressing real and imagined barriers to appropriate permanent placements, to be derived from research, professional experiences, and apparent best practices.

Survey Method

On October 1, 1992, the four Family Specialists serving FIAP on its Individualized Support Team (IST), responded to an eight page survey. The survey sought their independently considered and confidential (unshared and undiscussed with any others persons), professional opinions regarding the clinical factors, characteristics and systemic variables they experienced which were most favorable and unfavorable to the welfare and permanency plans of the seriously at risk foster children they had been serving for about 18 months. Additionally, they were asked to identify which of the variables they reported most typified their experiences. By this method, FIAP hoped to discover and describe any commonalities, first among clinical/system characteristics and variables that were believed to be most helpful and hurtful, and secondly, among those which appeared to be most typical of the system of care for foster children in Hillsborough and Polk Counties. The following is a synopsis of the individual and combined results of the survey.

It should be noted that FIAP does not claim any statistical validity or reliability for either the method or the outcomes here reported. Clearly, however, certain commonalities resulted which appear to indicate an important level of both professional content validity and confirmation of the probable reliability of these findings. In any case, these results certainly describe the experiences of four highly motivated and professionally savvy, empowered case managers, as they set about the challenging tasks of doing whatever appeared to be necessary to enhance the acquisition and effectiveness of clinical and related services for their case loads of from 12 to 15 foster children and their families.[2]

Instrumentation

This survey attempted to obtain the data-informed, professional opinions of four Family Specialists (empowered clinical case managers) as to those factors and characteristics of the children on their case loads, of their clients' care takers, of their clients' service providers, and of the entire system of services for children and families, which most severely handicapped and enhanced progress towards the planned service and outcome goals of those children. The instrument was an eight page printed document which breaks down conceptually into five sections. First, eight items (**A-H**) sought negative information (e.g., roadblocks, see Table 1), second, five items (**J-N**) sought positive information (e.g., helps and enhancements, see Table 2). Items **I and O** sought discrimination of the factors most often observed in field, in both categories,with sometimes more than one response per item, per respondent. Tables 1 and 2 show both the number of times each item was nominated for most often observed, as well as the number of times each item was mentioned for each question. A final item (**P**) sought recommendations for "systems changes that need to be made that...would most positively affect the progress of..." the children being served (See Table 3).

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[2] Thanks are due the four Family Specialists, named as the last four authors, for their diligence and forthrightness in their responses, as well as in their jobs.

Instructions. Written instructions were: "It is essential that (we) have the following information from each of you, independently from each other, as soon as possible.... The data requested are among the most important that you possess, about your children and this program. Please note that for items A through O, your examples should be factual, hopefully observable and measurable. Item P is an interpretation item, in which you may blue sky, based directly on your professional experiences as an IST Family Specialist."

Results

What follows are tabular representation of the entire survey, each item of which is followed by the four Family Specialists' answers distilled, aggregated and summarized, seriatim.

The first column of Tables 1 and 2 represents the number of Family Specialists who asserted that the factor or characteristic identified was one most/more often observed in field, per item.

The second column indicates the number of times a form of that response appeared, across the four Family Specialists, per item.

Though there was a possibility for five responses per item (totaling 20), some items were answered by more and some by fewer than five.

Discussion

Based on the tabular data, and the findings of qualitative and quantitative studies of Florida and other states, the foster care system at large should consider reform efforts to include at least the following:

A. ***Prevention***: Provide coordinated, collaborative family support and training systems for improved family self-sufficiency, to head off factors provocative of abuse and neglect;

B. ***Preservation***: Refocus dependency child welfare efforts on intensive in-home services for ***families in crisis*** (not children, only), to minimize the likelihood of a child's removal;

C. ***Reunification***: Mandate creative, individualized permanency plans, to ensure that out-of-home placements are minimized and reunification is maximized;

D. ***Integration of Individualized Services for Families In Crisis***: Generate effectively planned, non-categorical and categorical, integrated, individualized services, based on assessments across the major life need domains of abused and neglected children ***and their families*** (including foster families), and implement such services by wrapping them around children and families, individually;

E. ***Increase and Improve Available Foster Families***: Establish improved systems for the recruitment, training, supervision, and maintenance of quality foster families;

F. ***Enhance Adoptions***: Improve monetary, training, and related support systems to encourage and ensure the success of adoptions of hard to place foster children;

G. ***Enhance Effectiveness and Accountability Across the Child Welfare System***: Lower case loads of all child welfare counselors (e.g., no more than 20 families); Train foster parents, foster and adoptions counselors (and supervisors), together, and include emphasis on preservation and reunification; Develop an interdisciplinary team (including biological and foster family members) approach to case work, to include intensive, empowered (with flexible funds) case management; Monitor effectively and consistently; Evaluate casework, care taking, and services by focusing on both process and outcome, and modify accordingly; and Improve employment criteria (credentialing) and salaries for dependency workers; and

H. ***Coordinate, Collaborate, and Integrate Most Family and Child Services, Across Child Welfare, Juvenile Delinquency, Education, Mental Health, and Physical Health, to the Extent Possible.***

Table 1
Negative Factors

A. In your opinion, list at least 5 examples of those *behavioral* (not emotional) characteristics you find in any/all your assigned children which *most severely* get in the way of their progress toward their planned goals.

Responses	# Specialists Nominating Attribute/Behavior as Most Often Observed N=4	# of Times an Attribute/Behavior was Listed N=4
Running Away	2	3
Physical Aggression	2	2
Delinquent Acts (e.g., larceny; breaking & entering)	2	2
Noncompliance With Adult Authority (e.g., in the home, school, and else where)	2	6
Sexual Misbehavior	0	2
Verbal abuse	0	2
Lying	0	1
Tantrums	0	2

B. In your opinion, list at least 5 examples of personality or *emotional* characteristics you find in any/all of your assigned children which most severely get in the way of their progress toward their planned goals.

Responses	# Specialists Nominating Attribute/Behavior as Most Often Observed N=4	# of Times an Attribute/Behavior was Listed N=4
Hopelessness/Powerlessness/Despair	4	7
Mistrust (e.g., failure to bond, "toughness/separateness," failure to take responsibility)	3	5
Low Self Esteem	1	2
Lack of Impulse Control	1	1
Fear of Discrimination	0	1
Blind to Parental Faults	0	1
Depression	0	1
Fear of Failure/Forms Attachments Too Quickly and Uncritically	0	2

Table 1 continued

C. In your opinion, list at least 5 examples of parent/foster parent *behavioral* characteristics which most severely get in the way of the progress of any/all of your children.

Responses	# Specialists Nominating Attribute/Behavior as Most Often Observed N=4	# of Times an Attribute/Behavior was Listed N=4
Shirks Responsibility/Commitment/Follow-Through/Misses Scheduled Meetings/Fails To Transport	4	8
Untrained/Uses Inappropriate Disciplinary Methods	2	4
Complaining About HRS and HRS Workers/Power Struggle With System	0	2
Only One of Two Foster Parents Actually Available	0	1
Motivated By Money, Only	0	1
Treating Certain Children Better Than Others	0	1
Scapegoats Children	0	1
Does Not Communicate	0	1
Does Not Pay for Normal Child Expenses (e.g., school pictures, band or sports equipment)	0	1

D. In your opinion, list at least 5 examples of parent/foster parent *personality/emotional* characteristics which most severely get in the way of progress of any/all of your children.

Responses	# Specialists Nominating Attribute/Behavior as Most Often Observed N=4	# of Times an Attribute/Behavior was Listed N=4
Self Centeredness (e.g., Putting their concerns ahead of kids'; Have kids for money, only; Lack of commitment to kids)	4	5
Closed Mindedness (e.g., Not open to new or other ideas; Too traditional, unwilling to change)	2	5
Negativity Towards Kids (e.g., "My kids never did that!"; Highly judgmental of kids' behavior; Extremely low tolerance for childish misbehavior; Manipulative/blames everything on the child; Quick to anger)	3	4
Unrealistic Expectations of Foster Children	2	3
Fear of Working With Biological Families	0	2
Either Unfeeling or Lacking In Emotive Support for Kids	0	1
Stressed/Frustrated/Angry	0	1

Table 1 continued

E. In your opinion, list at least 5 examples of *behavior* characteristics of system workers (specify types of workers) you have encountered which you believe to be most severely disruptive in their impact on the progress of your children.

Responses	# Specialists Nominating Attribute/Behavior as Most Often Observed N=4	# of Times an Attribute/Behavior was Listed N=4
Poor Organization and Contents of Case Files	5	9
Yelling At, Lecturing, Discouraging, and Judging Biological Parents/Families	1	1
Worker Turnover or Reassignment	1	1
Inflexibility (e.g., With permanency plans)	0	3
Ignorance/Naiveté (e.g., About the system and/or their cases)	0	2
Unwilling To Take Risks	0	2
Crisis Orientation, Only	0	1

F. In your opinion, list at least 5 examples of *personality/emotional* characteristics of system workers (specify types of workers) you have encountered which you believe to be most severely disruptive in their impact on the progress of your children.

Responses	# Specialists Nominating Attribute/Behavior as Most Often Observed N=4	# of Times an Attribute/Behavior was Listed N=4
Feeling Unsupported By Colleagues and Administrators	2	2
Staff Centered, First, Child Centered, Second; Not Remotely Family Centered ("Negative bias towards biological families")	1	3
Unwilling To Take Risks	1	1
Overwhelmed With Work Load and Responsibility	1	1
Culturally Insensitive (e.g., Imposing middle class values on streetwise kids)	1	2
Eternally In Crisis	1	2
Believing They Must Be Hard On Both Foster Children and Biological Families (e.g., being the "enforcer" with kids; the "critical parent" with biological families)	0	2
Feeling Helpless and Overwhelmed	0	2

Table 1 continued

G. In your opinion, list at least 5 examples of *system problems* which most severely deter the progress of your assigned children and families.

Responses	# Specialists Nominating Attribute/Behavior as Most Often Observed N=4	# of Times an Attribute/Behavior was Listed N=4
Services Are Too Categorical (Not Integrated), Conditional, and Are Not Individualized (e.g., absence of flexibility to individualize for the child, much less the family–either foster or biological)	2	3
Too Few Appropriate Foster Home Placements	2	2
Ridiculously High Case Loads for Foster Counselors (e.g., an average of 47)	1	2
No Comprehensive Assessments of Foster Children or Their Families	1	1
Resistance To Change Found In Almost All Foster Staff–From Foster Parents To Top Administrators (e.g., Negativity towards misbehaving children and non-coping, abusing or neglectful parents is virtually universal; safety of each child is a much higher priority than the reunification or preservation of families)	1 1	1 1
Very Little Belief or Investment In Biological Families (Despite the fact that over 95% of all foster children return to their original homes, eventually, no matter what!)	0	2
Lack of Networking/Mutual Support and Cooperation	0	2
Not Nearly Enough Funds Available for Necessary Services	0	2
Disastrously High Turnover In Both Foster Line and Supervisory Staff	0	1
Poorly Planned, Executed, Monitored, or Evaluated Performance Agreements (i.e., they are usually ineffective or worse)	0	1
Crisis Orientation At All Levels	0	1
Negative Effects of Consent Decree On "A-F" Class Action Suit (e.g., careless, knee jerk haste to find quick fixes for children who need carefully wrought, individualized permanency plans)	0	1

Table 1 continued

H. In your opinion, list 5 examples of *child/family situational or circumstantial aspects* (e.g., age, living conditions, jobs, education, etc.) of your children/families which most severely hinder their progress.

Responses	# Specialists Nominating Attribute/Behavior as Most Often Observed N=4	# of Times an Attribute/Behavior was Listed N=4
Economics (e.g., poorly paying jobs for poorly trained, often otherwise stressed, poorly trained parents; housing; poverty; no funds for child care or transportation)	3	10
Poor Parenting Skills	2	3
Drug Addiction	1	1
Lack of Extended Family Supports	1	1
Ignorance of Available Services	0	1
Too Little Family Assistance Before Children Reach Their Teens, When It Is Often Too Late For Preservation	0	1
Foster Children Staying In Middle Class Homes, Then Returning to Poverty	0	1

Table 2
Positive Factors

J. In your opinion, apart from the *absence* of these negative factors, list at least 5 examples of those *positive behavioral or emotional factors* you see in any/all of your children, that are most effective in moving them toward their goals.

Responses	# Specialists Nominating Attribute/Behavior as Most Often Observed N=4	# of Times an Attribute/Behavior was Listed N=4
Strong Desire To Belong To a Family	2	3
Ability To Build Trust, Good Relationships, and To Care About Others	1	4
Good, Age Appropriate Behavior In All Settings	1	3
Ability to Express Feelings and Understand Them	1	3
Positive Self Image	1	2
Resilience and Adaptability	0	2
Involves Self In Home, School, and Community Activities	0	1
Ability To Enjoy School	0	1

K. In your opinion, apart from the absence of negative factors, list at least 5 examples of those *positive behavioral or emotional factors* you see in any/all of your parents/foster parents, that are most effective in moving your children toward their goals.

Responses	# Specialists Nominating Attribute/Behavior as Most Often Observed N=4	# of Times an Attribute/Behavior was Listed N=4
Openness To Support, Encouragement, and New Ideas From Others	3	7
Putting the Child's Welfare Ahead of Their Own	2	6
Commitment To Work With Their Opposite Numbers (e.g., Foster parents with biological parents, and vice versa)	2	2
Feeling Empathy for Others	1	1
Good Self Images	0	1
Strong Sense of, and Commitment to, Family	0	2

Table 2 continued

L. In your opinion, apart from the absence of negative factors, list at least 5 examples of those *positive behavioral or emotional factors you see in any/all of the system workers* you have observed, that are most effective in moving your children toward their goals.

Responses	# Specialists Nominating Attribute/Behavior as Most Often Observed N=4	# of Times an Attribute/Behavior was Listed N=4
Openness and Commitment To Working With Others (e.g., Open to support, suggestions, and encouragement; Openness to changes in opinions about children, parents, et al.; Open to reframing old ideas about others; Interacts well with others; Willingness to listen and reserve judgment; Team players; Able to build solid relationships with others; Willingness to advocate for system changes)	7	10
Follows Through (e.g., Completes assigned tasks; Attends meetings; Works hard)	0	3
Able To Take Risks	0	1
Having Hope	0	1

M. In your opinion, apart from the absence of negative factors, list at least 5 examples of *positive systems factors (other than person-related)* which have been most effective in moving your children toward their goals.

Responses	# Specialists Nominating Attribute/Behavior as Most Often Observed N=4	# of Times an Attribute/Behavior was Listed N=4
Efforts To Integrate Services	1	2
18 Month Dependency Review	1	1
Judges Willing To Back Reviewed and Updated Permanency Plans (e.g., IST coordinated plans);	1	1
An Openness to Coordinated Wrap Around Services	1	1
Guardian Ad Litem Activities, Generally	1	1
Separation of Foster Care and Adoption Services	0	1
Some Improved Willingness To Take Risks	0	1
Some Improved Permanency Plans	0	1

Table 2 continued

N. Apart from the absence of negative circumstances, in your opinion, list 5 examples of *child/family circumstances or situations which appear to have the greatest positive impact* on the children/families in your case load.

Responses	# Specialists Nominating Attribute/Behavior as Most Often Observed N=4	# of Times an Attribute/Behavior was Listed N=4
Survival Skills	1	1
Commitment To Connecting Siblings and Working Toward Reunification	1	1
Extended Families and Other Collateral Support Groups	1	3
Families That Want To Be Together	0	2
Willingness To Consider IST Methods	1	1
Improved and More Interactions Between Foster and Biological Families	0	1
Successful Adoptions	0	1
Biological Parents Who Seek Improvement Through Training or School	0	1
Some Improved Empathy and Commitment to Families	0	1

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Table 3
Recommendations for Change

P. Finally, list 5 *systems changes that need to be made* that, in your opinion, would most positively affect the progress of children like your children, in the future. (*NOTE*: Family Specialists were not asked to prioritize their responses to this item in any manner. Thus, numerals following their distilled responses indicate the number of times they appeared, overall.)

Responses	# of Times a Recommendation was Listed N=4
Foster Care Services Should Be *Family* Centered, Intensively Case Managed, Individualized and Integrated By Carefully Wrought Permanency and Service Plans, Flexible and Flexibly Funded, Both Categorical and Non-Categorical, As Needed. (e.g., Do intensive 1:1 work with families; Immediate wrap around and case management services, with focus on parent and family habilitation and/or rehabilitation; Coordinate services; Intensive case management for *each* family, to connect with community and services; Written service plan, task analyzed, time lined, within 30 days of disposition; Family centered and accountable)	6
Lower Foster Counselor Case Loads To No More Than 20 Families	3
Emphasize Family Preservation Prior To Child's Removal	2
Greater Accountability for Service Delivery, Across the Board (e.g., Pull contracts if services are not timely and appropriate; Services must be accountable to effective outcomes, as well as process)	2
Funds Must Increase, Become More Accessible (Less Categorical), Incorporate All Available Sources (e.g., Medicaid), and Accountably Spent for More and More Effective Services	2
More Foster Parents and Foster Counselors, Trained Together, To Work In Teams and To Be More Respectful, Supportive, Consistent, and Diligent In Working With Their Families	2
Organize the Foster Care System To Give Incentives for Reunification and Thoroughly Planned Permanency Plans	1
Provide Immediate, Consistent, and Effective Mental Health Consultants/Team Members to Every Foster Care Unit	1
More In-Home Services (e.g., Parent and foster parent support, in-home training, family therapy, etc.)	1

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Treatment Foster Family Care: North American Developments

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Snowball sampling techniques were used to identify treatment foster care (TFC) in the United States and Canada. Mail questionnaires were used to obtain information from 434 programs on resources used and activities carried out. Of these, 321 indicated that all six TFC attributes applied to their program. Almost three-quarters are operated by private not-for-profit agencies, 9 out of 10 have been established since 1980 and are relatively small with approximately half reporting an annual budget between $101,000 and $500,000. Almost three-quarters of the programs pay caregivers on a per diem basis for each child placed. Almost all programs report requiring caregiver training prior to client placement as well as annual training. Over two-thirds of the programs require caregivers to attend support group meetings, most commonly on a monthly basis. Almost all of the programs report using treatment plans, usually covering three months. Most programs report having policies that encourage birth parent visiting as part of treatment plans and also encourage professional staff to consult with parents as a normal part of placement planning and treatment. Almost two-thirds of the programs train caregivers in a particular treatment approach. Behavior modification is the most used. Most programs set maximum caseload sizes and most maximums are set in terms of clients, rather than treatment foster care homes.

Introduction

The 1990s have seen treatment foster care programming (TFC) established in the spectrum of social services with a professional organization established, annual North American conferences held since 1987, a professional journal produced, books and monographs published, and a set of draft certification procedures issued. These developments have coincided with a dramatic growth in the number of treatment foster care programs. In this paper we present some of the results of a recent survey.

Origins of Treatment Foster Family Care. The historical development of contemporary TFC programs have been traced by Galaway (1992), Hawkins (1989), and Bryant (1981). In his analysis, Galaway views TFC programs as evolving from two historical roots: regular foster care and residential treatment services for youth.

The route from regular foster care is seen by Galaway as evolving through the stages of free homes, boarding homes, and difficulty of care rate homes. Most notable was the work of Charles Loring Brace and Charles Burtwell, along with the

1961 amendments to the Social Security Act. These amendments provided federal cost sharing for difficulty of care rates for challenging young persons and from these payment arrangements with individual foster parents came payments to programs organized to recruit, train, and pay foster parents to provide treatment services to challenging youth. The second historical strand identified by Galaway for contemporary TFC programs were residential treatment services for children. As noted by Bryant (1981), as early as the 1960s several residential treatment programs were developing treatment foster homes to supplement or serve as an alternative to retaining children and youth in the institutional settings. With the emphasis on deinstitutionalization during the 1970s and 1980s movement out of residential treatment and into treatment foster family care accelerated.

Robert Hawkins (1989) has identified ten developmental streams contributing to the popularity of TFC. Among these are regular foster family care, institutional care and residential treatment centers for children and youth, outpatient treatment of children and their families, parent training, services to the child's ecology, awareness of the need for child mental health services, growing emphasis on behavior change technology, the deinstitutionalization movement, and increased emphasis on cost cutting and accountability.

These different historical forces gave rise to a number of pioneering TFC programs in Canada, the United States, and England during the early 1970s. Some of the best known were the PATH program established in Minnesota in 1971 (Galaway, 1978), the Hamilton, Ontario, Parent-Therapist Program established in 1972 (Levin, Rubenstein, Streiner, 1976), the Parent Counselor's program in 1974 in Alberta, Canada (Larson, Allison, and Johnston, 1978), and the Kent Family Placement Project in 1974 in England (Hazel, 1981).

Towards a Definition of Treatment Foster Care. The definition of treatment foster family care and the key terms used are on-going issues. An array of terms are used; for example, specialist foster family care (Galaway, 1989), specialized foster care (Snodgrass & Bryant, 1989), family-based treatment (Hawkins & Meadowcroft, 1984), foster family-based treatment (Hawkins, Meadowcroft, Trout, & Luster, 1985), professional parenting (Jones & Timbers, 1983), parent-therapist (Rubenstein, Armentrout, Levin, & Herald, 1978), individual residential treatment (Update, 1986b), parent-counselors (Larson, Allison, & Johnston, 1978), teaching-parents (Maloney, Fixsen, & Phillips, 1981), along with such designations as therapeutic family care, therapeutic foster care, treatment family care, professional foster care, and intensive foster care (Stroul, 1989).

Several attempts have been made to define treatment foster care practice (Hawkins, 1989; Snodgrass, 1989; Galaway, 1989; Snodgrass & Bryant, 1989; Webb, 1988). Major differences are evident. Robert Snodgrass (1989), for example, emphasizes family based treatment with the foster parents responsible for carrying out individually designed treatment interventions. The treatment plan is designed by mental health experts but implemented by the foster parent under supervision and guidance of the professionals. Snodgrass argues that a program cannot be considered foster family based treatment unless there is a range of mental health professionals on staff capable of delivering various treatment services. This contrasts with Galaway's (1989) emphasis on normalization and the development of social networks. From this approach the child in placement is to experience family life, although the foster parents may need training and support to cope with the specific, sometimes exaggerated, behaviors presented by the young person. The emphasis is on family living as both the means and context of service. The notion of networking implies that service efforts are directed at assisting young persons develop informal social support systems as well as accessing formal services within the community (Whittaker and Maluccio, 1989, pp. 96-97). These latter might include mental health services secured from community providers just as medical services, dental services, and other types of services are secured in the community rather than being provided by the treatment foster care program.

While different views persist, consensus is emerging that the following elements are necessary for a treatment foster care program (Galaway, 1990, 1989; Snodgrass, 1989; Hawkins, 1989; Stroul, 1989).

1. Care is provided within a family setting — a home owned or under the control of the foster care providers;
2. The program is targeted to children and youth who would otherwise be in more restrictive settings (usually institutions);
3. Programs have clearly articulated philosophy with strong community linkages and individual treatment and educational plans;
4. Foster care providers are selected and trained to provide care to children and youth who have special needs that may result from emotional disturbance, developmental disabilities, behavioral difficulties, special medical needs, or special cultural needs;
5. Foster care providers receive support, consultation, and supervision from human service professionals who carry a limited case load.
6. Foster care providers receive payment above and beyond the out-of-pocket cost of providing care.
7. The treatment foster family care program is administered by agencies specializing in treatment foster care or, if part of a host agency, by a unit specifically identified as a treatment foster care program.

Program Surveys. The information presented here is from the most recent of five surveys of North American treatment foster care (TFC) programs. A survey with 48 responding programs was done in 1984 by Snodgrass and Bryant (1989). Pamela Meadowcroft (1989) reported on 100 programs by collecting information from attendees at the 1987 North American Treatment Foster Care Conference. A survey with 157 responding North American TFC programs was done in 1987-88 by Nutter, Hudson, and Galaway (1989) who then replicated that survey reporting on 293 TFC programs operating in North America in 1989 (Hudson, Nutter, and Galaway, 1992). The survey reported here was done in 1991-92. It expanded on the 1989 survey by collecting information on both program characteristics and clients of 321 TFC programs operating in North American during Fall 1991.

Methodology. Snowball sampling techniques were used to assemble a list of North American TFC programs. The initial listing was based on the earlier surveys reported by Nutter, Hudson, and Galaway (1992), supplemented by the list of registrants at the Fourth North American Treatment Foster Care Conference, along with a list maintained by the Foster Family-Based Treatment Association. The combined mailing list from these different sources totaled 1255 persons in the United States and Canada.

The survey was then done in six passes. In early September, 1991, brief questionnaires were distributed to the 1255 persons identified with foster care programs in Canada and the U.S.A. to discover if they met the following six criteria for a treatment foster care (TFC) program:

1. The program is explicitly identified as a specialist or treatment foster care program with an identifiable name and budget.
2. Payments are made to treatment foster care takers at rates above those provided for regular foster care.
3. Training and support services are provided to the treatment foster care takers.
4. A formally stated goal or objective of the program is to serve clients who would otherwise be admitted to or retained in a non-family institutional setting.
5. Care is provided in a residence owned or rented by the individual or family providing the treatment services.
6. The treatment foster career is viewed and dealt with as a member of a service or treatment team.

Reminder letters were sent to programs that had not responded by the end of September, 1991. From these responses, 808 programs were identified that claimed to meet all six TFC attributes. In early November, 1991, questionnaires were sent to each of these programs. Two weeks later reminder/thank you cards were sent. In late December, 1991, questionnaires were again sent to those programs not yet responding. In late January, 1992, questionnaires were again sent to the programs still not responding. By April 1, 1992, usable responses had been received from 434 programs. Of these, 321 indicated that all six TFC attributes applied to their program. These 321 TFC programs are described here.

Survey Results

Program Auspices and Year Established. Figure 1 shows almost three-fourths (234) of the 320 programs were operated by private not-for-profit agencies, almost another quarter (73) by government, and very few (13) by private for-profit agencies. These proportions are very similar to those reported in the 1989-90 survey, with only a slight increase in the proportion of not-for-profit agencies and a slight decrease in programs operated by for-profit agencies.

Figure 2 shows that the majority of programs (61%) were established in the 1980s, slightly more than a tenth (12%) in the 1970s, and slightly more than a quarter (28%) in the 3 year period, 1990-1992. The recency of this program thrust is underscored by the fact that almost 9 out of 10 programs have been established since 1980; only 7 programs (2%) operated prior to 1975.

Program Resources. A series of survey questions dealt with program financing, including annual budget, and caregiver compensation. Of the 244 programs reporting information on annual budget, the mean was $848,700, and the median, $425,500. As shown

Figure 1
Auspices of TFC Programs
N = 320

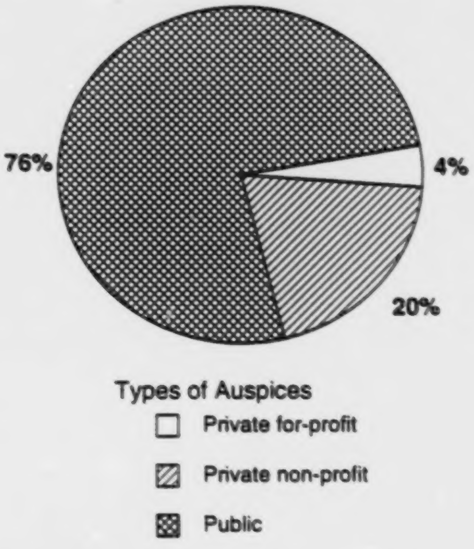
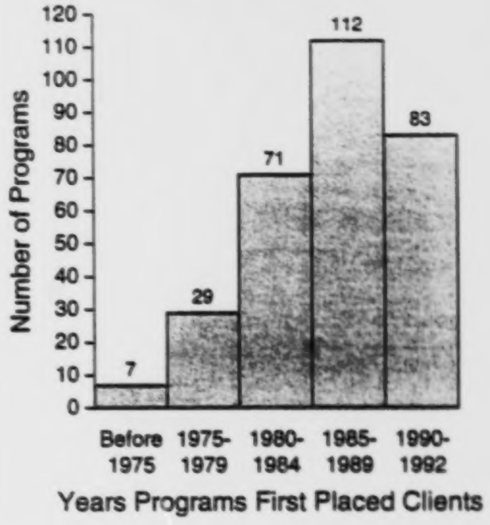


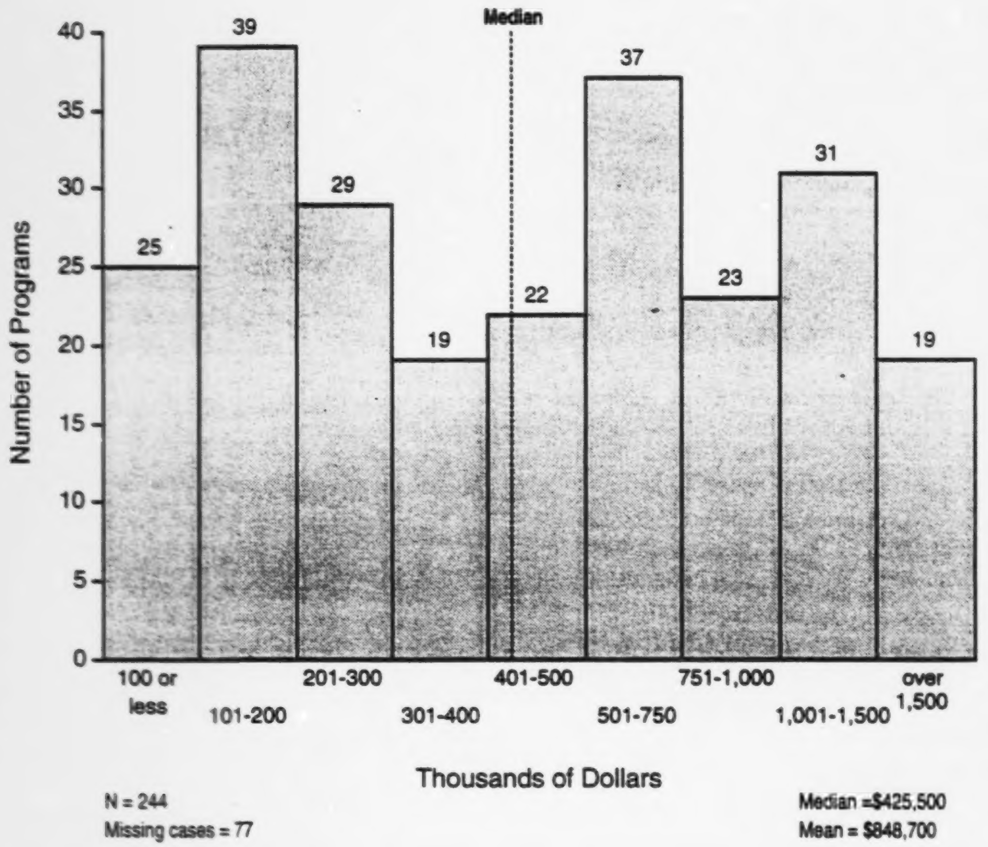
Figure 2
When TFC Programs Were Established
N = 302



in Figure 3, approximately one-fifth (21%) of the programs report an annual budget exceeding one million dollars, while at the other extreme, a tenth report an annual budget of $100,000 or less; almost half (45%) report an annual budget between $101,000 and $500,000. While the programs tend to be relatively small, as evidenced by four-fifths of them having annual budgets under one million dollars, there has been growth, as shown by comparing them with the results of the 1989-90 program survey that found a mean annual budget of $685,509 and a median of $331,000.

Annual budget information on treatment foster care programs can be misleading since a considerable portion of program income flows directly to foster caregivers in the form of compensation. Respondents were therefore asked to provide information about the total amount of the annual budget allocated for the compensation of foster caregivers. The programs

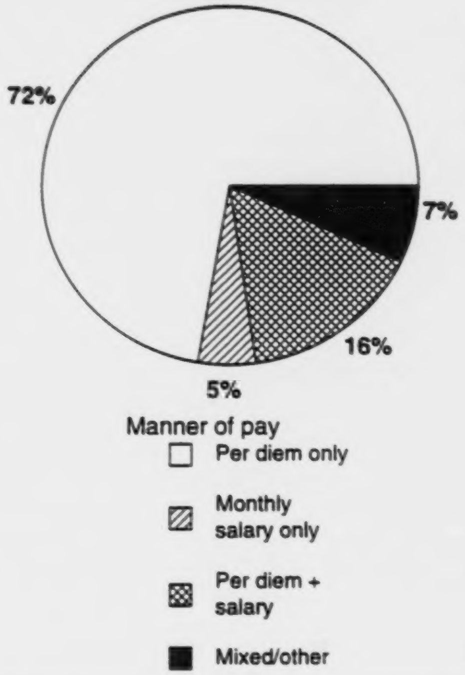
Figure 3
Total Annual Budgets of TFC Programs



reported a mean amount allocated to foster caregivers of $435,300 and a median amount of $210,000. In short, approximately half the program income flows directly to foster caregivers as compensation.

Programs were also asked to provide information about the basis for compensating caregivers, as well as the amount of these payments. Figure 4 presents information on the various ways foster caregivers were paid. Almost three-quarters (72%) of the programs pay their caregivers on a per diem basis for each child placed, while less than one fifth of programs (16%) pay caregivers a fixed retainer plus additional compensation for each day of care actually provided. Very few programs (5%) pay a fixed retainer regardless of whether a client is in care, and a small number (7%) of programs use such compensation arrangements as per diem plus room and board, or per diem plus recreation or training amounts. As compared to the 1989-1990 survey, an increased proportion of programs are paying their foster caregivers on a flat per diem basis (from 51% to 73%), while proportionately fewer programs use retainers (from 19% to 5%).

Figure 4
Manner of Paying TFC Caregivers
N = 316



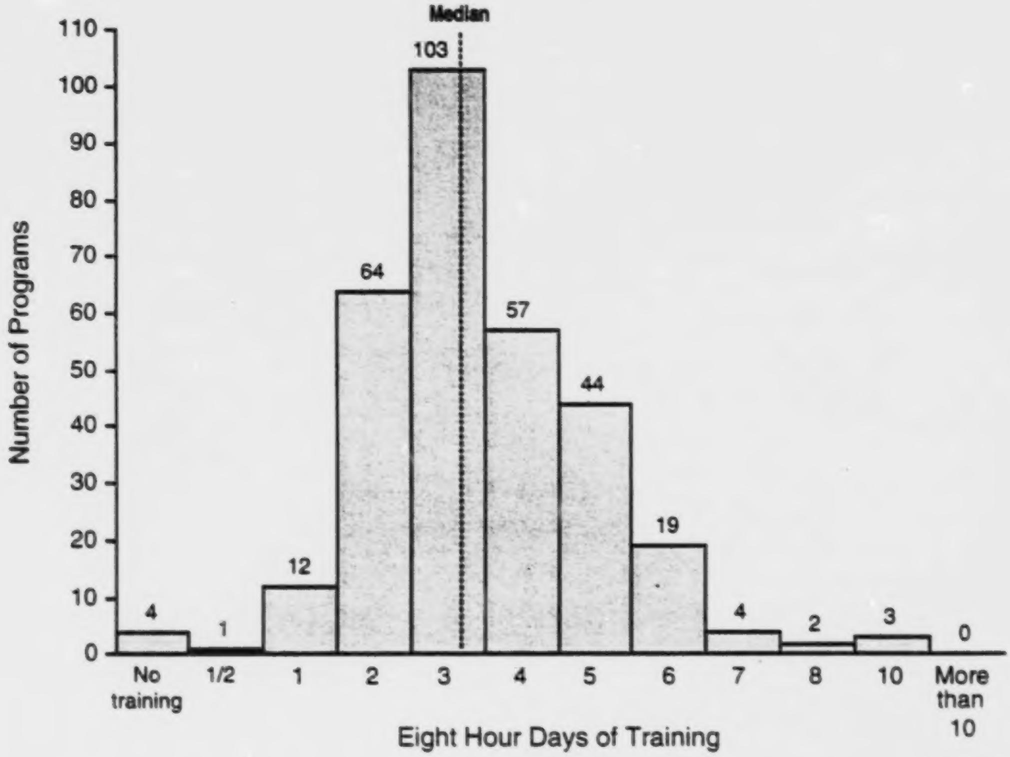
Program Activities. Information was requested on service activities commonly associated with treatment foster care programming, including caregiver training, use of support groups, treatment planning, nature of intervention techniques, birth parent involvement, and social worker supervision and support. Almost all programs (99%) reported requiring caregiver training prior to client placement, with an overall mean of 25 hours and median of 21.

As evident from inspection of Figure 5, approximately a quarter of the programs require from 4 to 16 hours pre-service training, another two-thirds (65%) require 24 hours to 40 hours, while almost another tenth (8%) require from 48-80 hours of training prior to client placement. These distributions are very similar to those found in the 1989-90 survey.

Continuing in-service training is also required by almost all of the programs as evident in Figure 6, with a mean of 23 hours and median of 20 hours per year. As with the pre-service training requirements and the earlier survey results, the range varies with approximately two-fifths of the programs requiring from 1 to 2 days, approximately half requiring from 3 to 5 days, and a few programs (9%) requiring in excess of five days annual caregiver training.

Another common element of treatment foster care programming is mandatory caregiver attendance at support group meetings. As evident from Figure 7, over two-thirds (68%) of the programs require that caregivers attend support group meetings, almost one-third (29%) do not, while an additional eight programs (3%) encourage, but do not require, attendance. Again, these proportions are very similar to earlier survey results.

Figure 5
Pre-service Training Required of Caregivers



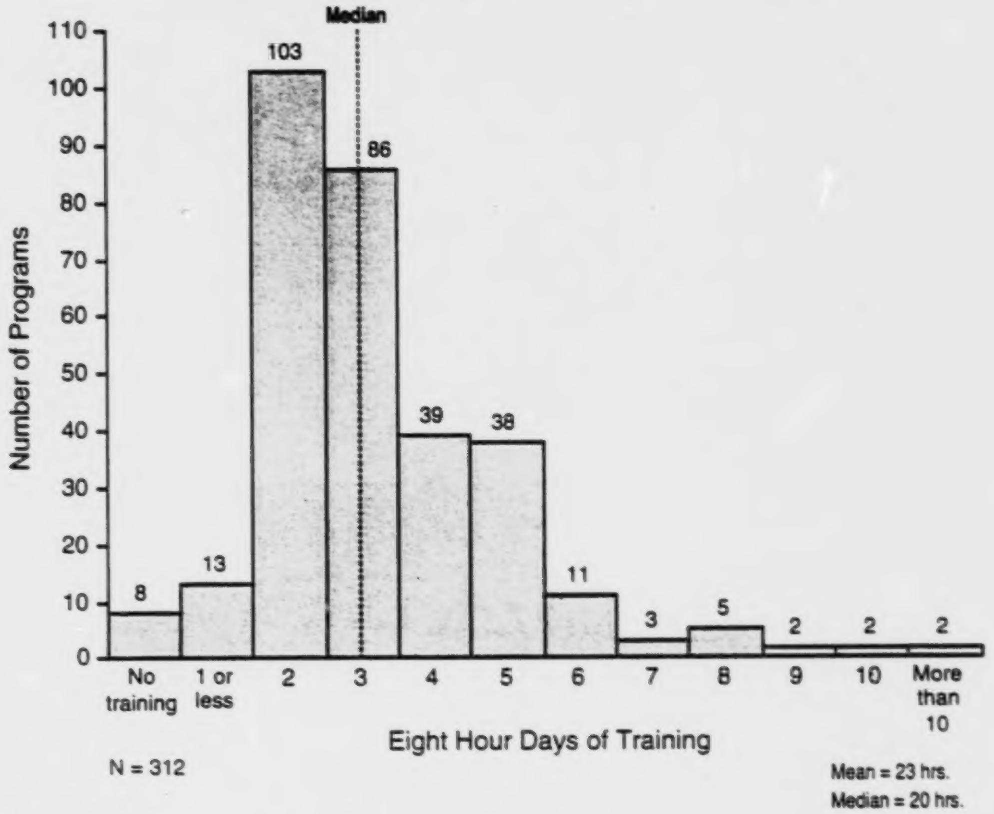
N = 313

Mean = 25 hrs.
Median = 21 hrs.

For the programs requiring participation in support groups, the mean annual number of meetings at which attendance is expected is 17, the median 12. Nearly one third (30%) of the programs require or encourage support group attendance more frequently than once a month, one third (33%) require monthly attendance while over one third (38%) require less than monthly attendance.

Almost all (98%) of the programs reported using treatment plans defined as "a *written document* that is client specific; specifies one or more interventions, activities, or tasks; specifies who is responsible for performing these activities, and will sometimes specify the goals or objectives expected to result from completing these activities." The mean number of weeks plans covered was 18, the median 12. Approximately two-thirds (66%) of the programs used treatment plans covering 12 weeks or less, in less than one fifth (17%) of the programs plans covered a 13 - 24 week duration, and for

Figure 6
In-service Training Required of Caregivers Each Year



one in seven (14%) of the programs treatment plans covered from 6 months to 1 year.

The surveyed programs were asked about their written policies to encourage parental involvement in the placement and treatment of their children. Almost all (95%) of 313 programs responded that their written policies encouraged parents' visits with their children as part of treatment plans. Over four-fifths (84%) reported their policies encouraged professional staff to consult parents as a normal part of planning for the placement and treatment of children. About three-quarters (78%) had policies to invite parents to meet with the professional staff and caregivers to plan the placement and treatment of their child. About one quarter (28%) of the programs' written policies encouraged parents to make a pre-placement visit to the TFC home. Approximately one tenth (12%) of programs had policies to offer services to parents such as counseling, workshops, progress reports, or accommodations to facilitate reunion of the child with the birth parents.

Figure 7
TFC Program Requirements for Caregiver Participation in Support Groups
***N* = 320**

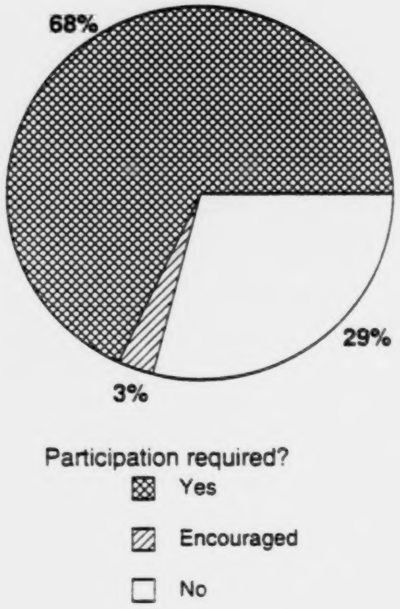
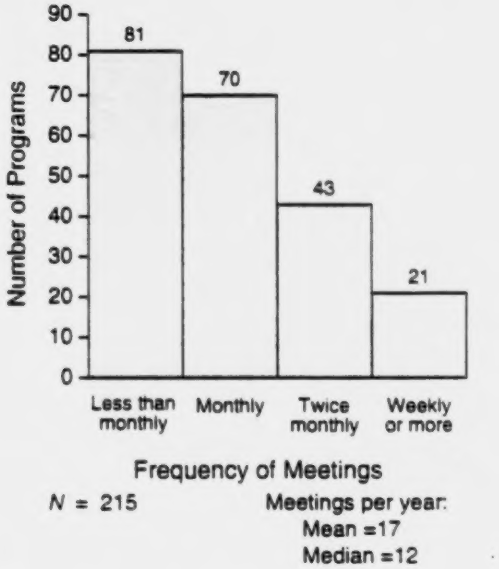


Figure 8
Frequencies of Support Group Meetings Caregivers were Required to Attend



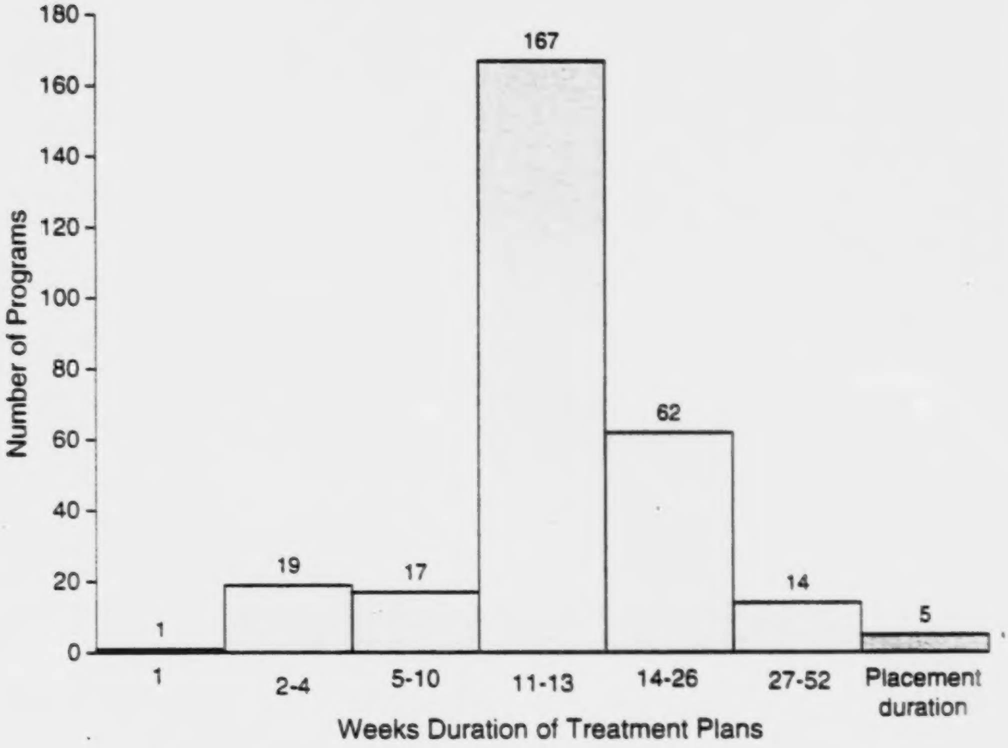
Almost two-thirds (62%) of the 314 program respondents indicated that their caregivers received specific training in a particular intervention technique or treatment approach. Slightly over one-third (38%) reported they did not train to a particular intervention approach.

Respondents were asked to indicate which of six intervention techniques or treatment approaches were used in their TFC programs. Of the 203 who identified approaches, about half (56%) chose behavior modification. Less popular with almost one third (30%) was a social learning approach. One quarter (26%) chose a systems, contextual, or ecological approach. Almost another quarter (23%) chose reality therapy, followed by smaller proportions reporting use of family therapy approaches (17%), and psychodynamic or insight approaches (13%). Although asked to select one major approach, about one quarter of respondents checked more than one.

As expected, almost all (99%) of the 317 programs providing information noted that social workers or other types of human service professionals were employed to work with the foster caregivers, clients, or parents. Nine of ten (89%) programs reported setting maximum case load sizes for these professionals. Nearly nine of ten (86%) programs reported case load maximums in terms of clients, not homes.

For the 243 programs using client case loads as maximums, the mean maximum was 11 and the median 10 clients, with a range of 2 to 25 clients. For the 40 programs using homes for setting case load maximums, the mean was 7, the median 7, and the range from 2 - 18 homes.

Figure 9
Time Frames of TFC Programs' Written Treatment Plans



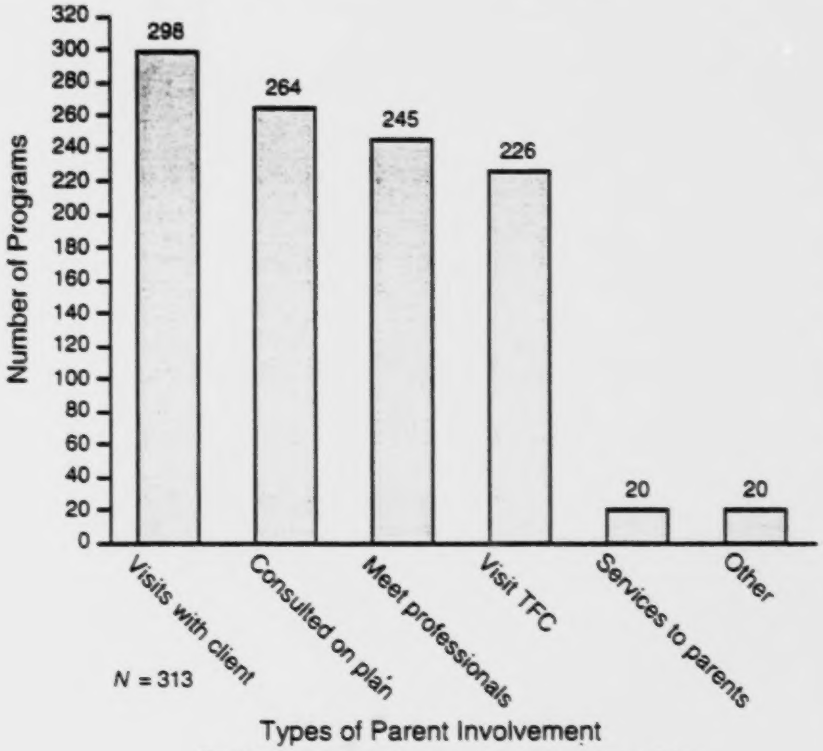
N = 286

Mean = 18
Median = 12

Summary and Conclusions

The survey reported here presents information on treatment foster care programs operating in North America during Fall, 1991. The programs were delivered mainly by private agencies, are quite small, and recently established. Key program activities were pre-service and ongoing training, the use of support groups, and written treatment plans. Most programs reported having policies that encourage parental visits with their children as well as professional program staff consulting with parents in planning for the child in the TFC program. Much smaller proportions of the programs encourage pre-placement visits to the TFC home by parents and only a few have policies stipulating that such services as consulting to be offered to birth parents.

Figure 10
TFC Programs' Written Policies for Involving Parents



Each program may have any or none of the policies

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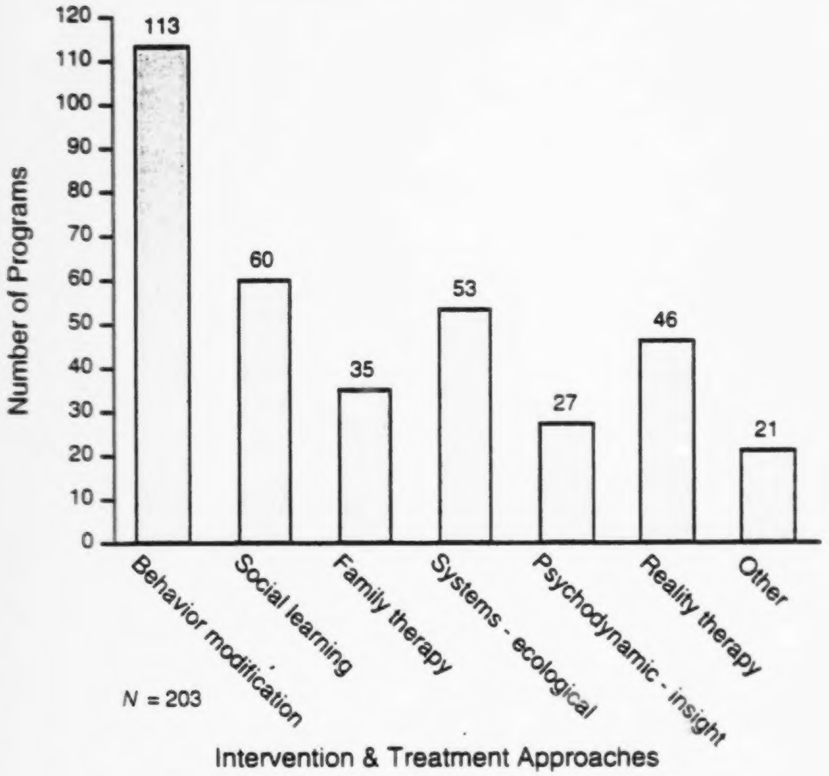
Figure 11

TFC Programs' Intervention or Treatment Approaches



Intervention & Treatment Approaches

Each program may have any or none of the approaches

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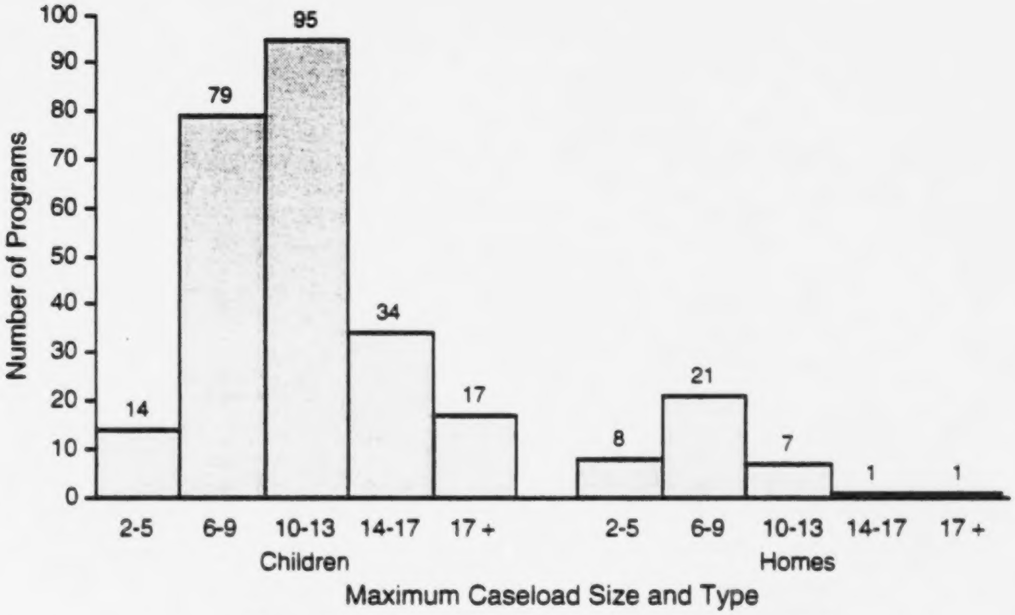
Figure 12
Maximum Caseload Size and Type for TFC Professionals



Mean = 11
Median = 10
N = 239

Mean = 7
Median = 7
N = 38

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An Individualized System Of Care For Foster Children With Behavioral And Emotional Disabilities: Effects On Juvenile Delinquency[1]

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The FIAP study (Fostering Individualized Assistance Program) involves a comparison of two methods of providing mental health and related services to foster children, at highest risk, randomly assigned to two groups: Standard Practice (SP) vs. Individualized Support Team (IST). The IST intervention model is family-focused, child-centered, collaborative, and uses an empowered (with a checkbook) case management strategy to implement an intensive program of individualized wraparound services. Although the FIAP study is examining the impact of this intervention model on all aspects of the children's lives (e.g., emotional and behavioral adjustment, placement permanency), this paper reports only the preliminary findings regarding delinquency.

Introduction

Many aspects of family functioning are related to delinquent behavior. For example, high rates of conflict have been found in families of delinquents (Gove & Crutchfield, 1982). Higher rates of delinquency are found in families with indifferent-uninvolved, or authoritarian parenting styles (Henggeler, 1989), in both chaotic and rigid families (Geismer & Wood, 1986), and in families with less warmth and more negativity (Henggeler, Hanson, Borduin, Watson, & Brunk, 1985).

Association with a deviant peer group has been found to be one of the strongest factors in the risk of delinquency (Hanson, Henggeler, Haefele, & Rodick, 1984; Fagan & Wexler, 1987), but the greatest risk seems to be for youth with poor family relationships and strong attachment to delinquent friends (Elliott, Huizinga, & Ageton, 1985). The foster children of the FIAP study have many of these risk factors, and thus are likely to display multiple problems, including delinquency.

The clinical purpose of the FIAP study was to establish a systematic program of individualized, wraparound care, support, and integrated mental health and related services for

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[1] The authors wish to express their appreciation to Joseph Kuhns, Karen Donohue, and Mark Rose for their assistance in data collection and analysis.

foster children with emotional/behavioral disabilities[2]. This intervention model, referred to as the Individualized Support Team (IST), is family-focused, child-oriented, and committed to establishing appropriate permanency settings for the foster children.

Significant differences or trends favoring the IST approach over SP were found one year after the start of the study in behavioral adjustment measures, number of acting-out incidents, placement circumstances, and progress toward permanency plans (Clark, Boyd, Redditt, Foster-Johnson, Hardy, Kuhns, Lee, & Stewart, 1992). The longitudinal design of this study, with random assignment to the two service delivery methods, created a unique opportunity to track these children in regard to delinquency activities. Thus, the purpose of this paper is to report on preliminary findings regarding the IST intervention method as related to its impact on delinquency.

Methods

Subjects

From a total of approximately 1,500 foster children in two large counties in Florida, 500-600 children ages 7 through 15 years had screening forms completed by their foster care counselors. This represented approximately 65% of the children who had been in foster care at least two months, who were in the appropriate age range. It is not known what characterized the 35% for whom screening forms were not received. Because there had been (and continues to be) much turnover among caseworkers and caseload assignments, it may be that many of those not screened were children with whom the caseworkers had insufficient familiarity (or insufficient time to research the records). It is also possible there were selective omissions of children for a systematic reason, such as being close to adoption or reunification, being in very stable homes, or otherwise having less need for screening in the caseworker's judgment.

Children selected for participation in the study from this referral pool were children with multiple problems, who had histories of abuse and neglect, and were characterized by maladaptive behaviors and other circumstantial indicators of high risk for severe emotional disturbance (Boyd, Struchen & Panacek-Howell, 1989), such as length of out-of-home placement, number of different placements, psychotropic medications, or illicit substance abuse. After they were selected, they were randomly assigned to either the IST or SP group, controlling for sex and race.

At entry to the study, the 132 children (54 IST and 78 SP) had been in foster care an average of 2.5 years and had experienced an average of more than 3 placement changes per year per child (range 1-22), while in foster care. More than 90% had documented histories of neglect and either sexual abuse, physical abuse, or both. These figures have obvious implications regarding the probability that these children would experience impairment of bonding with both biological and foster families, and thus the potential for increased peer group influence, which may be negative (Henggeler, 1989).

Measurement Parameters

Definitions

Juvenile delinquency is defined as violations of the law by persons not yet 18 years of age, which, if committed by an adult, would have been a crime. So-called status offenses, such as running away from home or being placed under HRS supervision as a child in need of services, also may show on records of juvenile delinquency, but are not included as offenses in these analyses, except where noted.

Case rates are the statistic in general use for reporting prevalence of delinquency, and are defined as the number of arrests officially recorded per 1,000 youths, ages 10 through 17 (Department of Justice, National Center for Juvenile Justice, 1992). Case rates differ from an individual rate, because some youth have more than one crime, and some may have numerous crimes recorded. The case rate statistic also represents only crimes for which arrests were made, not the actual incidence of delinquent acts. If more than one crime is charged at one arrest, the case rate uses the most serious crime recorded for that date.

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[2] At the heart of the IST intervention are the Family Specialists. The authors wish to acknowledge the dedication, expertise, sensitivity, cooperativeness, and professionalism that Beth McDonald, Roxanne Fixsen, Yolanda Boronell, Tom Andrews, and Richard Hartsfield have brought to children and families.

The case rate allows comparisons in the prevalence of juvenile delinquency between demographic or other groups, and can be used as an outcome measure (Huizinga & Elliott, 1987).

Pre and post intervention were generally defined as before or after the initial interview of the child and foster family by the research team. However, after a child was assigned to the IST group, approximately 30 days passed before active work with the child and family began. The judgment was made that by 3 months after the initial interview, the IST approach would be adequately implemented to begin yielding some effect on delinquency records. Thus, for these analyses, the time after entering foster care but pre-FIAP included this 3-month period, and the post-FIAP time for both groups started 3 months after the first interview by the research team[3].

Results

Delinquency Histories

Of the 132 children in the FIAP study, 16% had some juvenile justice record prior to entering foster care.[4] This figure is surprisingly high in light of the fact that the children were less than 5 to 13 years old when they came into foster care. Because the intent of foster care is to place children into safe, stable environments temporarily, in which their needs will be met (in contrast to their biological homes in which most had histories of neglect and/or abuse), their histories subsequent to foster care placement and after permanency are of the greatest concern to clinicians and researchers. Therefore, the juvenile justice records before placement in foster care, after foster care placement, but before the FIAP study, and after the FIAP study, were considered separately in the following analyses.

There were no significant pre-foster care or pre-FIAP differences between IST and SP groups in percent of children with delinquency histories or in the kinds of offenses recorded (e.g., misdemeanors, felonies, sexual crimes). Overall, 39% of the 54 children in IST and 44% of the 78 in SP had some record in the juvenile delinquency system as of March 1993, including status offenses. Forty-five of the 132 children (34%) had committed crimes designated as juvenile delinquency. In spite of the average age at entry to foster care being well below the age for children at prime risk for delinquency, the case rate for these 132 children prior to entering foster care was 114 arrests per 1,000 youth, compared to the national case rate of 47 per 1,000 youth (U.S. Department of Justice, 1992), and the Florida case rate of 95.4 per 1,000 youth (Department of Rehabilitative Services, 1992).

After entering foster care, but prior to entering this study (pre-FIAP), 37 (28%) of the 132 children had 138 recorded arrests. This is the equivalent of a case rate of 1,045 arrests per 1,000 youth across all 132 children (with no significant difference between IST and SP), 11 times larger than the rate for all Florida youth, and 22 times greater than the national case rate.

Delinquents Arrested During Post-FIAP Period

The next analysis examines delinquency during the FIAP project for children in either IST or SP who had any record of delinquency before entering foster care, after entering foster care, but before the FIAP project began, and after the FIAP project started. The first two bars of Figure 1 show that a larger proportion of the IST children (35% vs 29%) had no arrests during the post-FIAP period. Although this is an interesting trend, the difference between IST and SP was not significant, with an odds ratio = 1.3, meaning that an IST child was 1.3 times more likely than a SP child to have no delinquency recorded after the FIAP project began, even though they had prior histories of delinquency.

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[3] The authors gratefully acknowledge the skill and sensitivity of the research interviewers, Julia Hartman, Kristi Weiner, Amy Thatcher-Benza, Mary Todd, Donna Romeo, and Julia Conklin.

[4] This percentage included children with status offenses which are not classified as delinquency.

The middle two bars of Figure 1 show that a relatively small proportion of both the IST (12%) and SP (18%) groups had no delinquency history either before entering foster care or in foster care, until the time after the FIAP project began. This is an expected finding, because delinquency normally increases with age during adolescence. The difference between IST and SP approached significance, with SP youth 1.7 times more likely than IST to be in this category (Odds Ratio 1.7, $p = .08$).

For those youths who had delinquency records both before and during the FIAP project (last set of bars, Figure 1), a smaller percentage of IST (59%) than SP (71%) had arrests during the FIAP time period, but this difference failed to reach significance (Odds Ratio 1.6, *ns*).

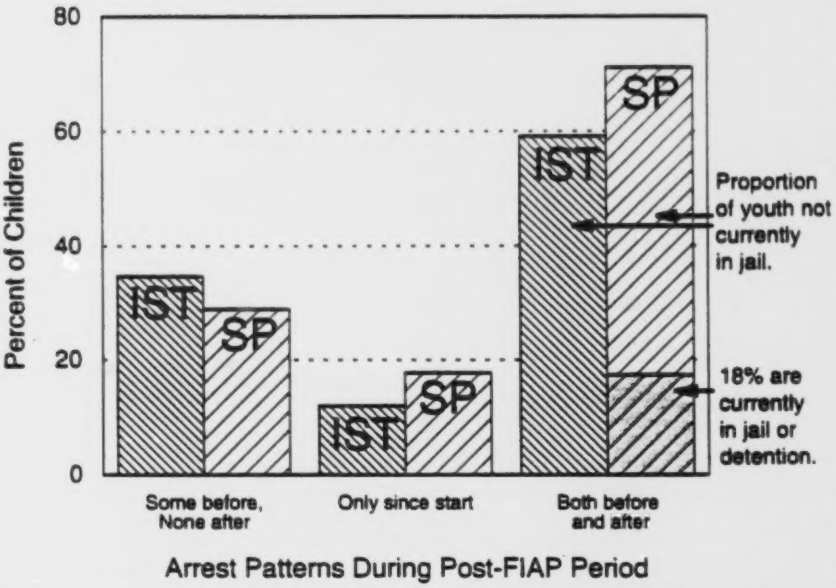
Case Rate Analysis Pre- and Post-FIAP

Figure 2 presents the pre/post arrest rates for the 54 IST children and 78 SP children, expressed as case rates. Because there was a considerable (although statistically non-significant) difference in case rates for the pre-FIAP time period, the post-FIAP differences also did not reach significance. The trend, however, was very encouraging, with a decrease of 43% in the case rate for IST youth while the case rate for SP remained essentially the same (1231 and 1256 arrests per 1000 youth, ANOVA $p = 12$, *ns*). The odds ratio indicated that IST youth were only 60% as likely to be arrested in the post-FIAP period, compared to the SP youth.

A sub-analysis was completed to examine the patterns of more serious crimes (felonies; punishable by 1 year or more, if an adult), misdemeanors (punishable by less than 1 year), and sexual crimes and prostitution. Although the pre-FIAP case rates for these three categories varied sufficiently between IST and SP so as not to be completely comparable in this size sample, the pre to post changes shown for IST showed case rate decreases for all three categories, while SP decreased only in misdemeanors, and increased substantially in both sexual crimes and felonies.

IST case rates for misdemeanors decreased from 222 to 92, and for sex crimes, from 74 to 0 arrests per 1,000 youth. The case rate for felonies decreased 15%, and the number of felonies recorded was significantly lower for the IST children compared

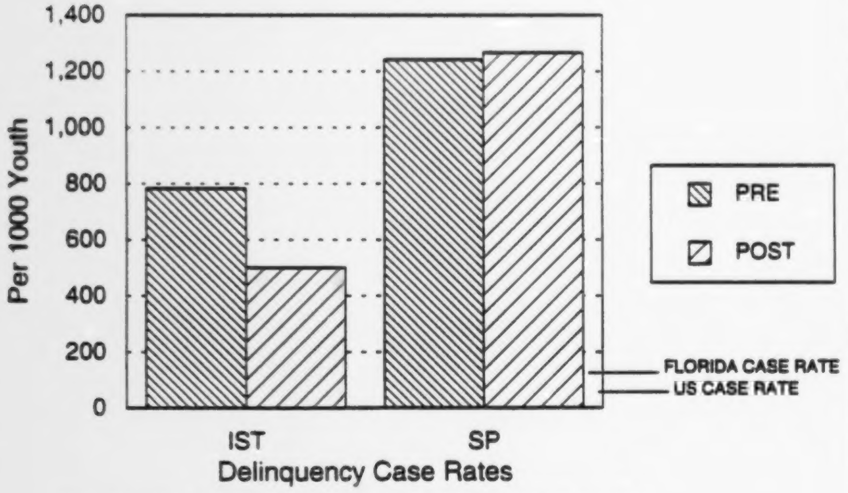
Figure 1
Arrest Records Before and After Start of the Study for Children with a Delinquency Record



to SP after the start of FIAP, but not before ($p = .03$). In contrast, the SP case rate for felonies increased by 12%, as did the case rate for sex crimes and prostitution (from 13 to 38) arrests per 1,000 youth. While the SP case rate for misdemeanors decreased 20%, the increase in felonies by SP children more than offset this decrease.

The meaning of the difference between SP and IST groups in the direction and amount of change in delinquency case rates should be viewed as conservative, in that the SP case rate was limited by the fact that several of the highest-rate offenders were in jail during large portions of the post-FIAP period (i.e., not available to commit crimes as shown in Figure 2). The last two bars of Figure 1 show that 18% (6 of 78) of SP children with any delinquency record were in detention or jail at the end of this current analysis, one-third of them serving extended sentences in adult facilities, and another one-third awaiting disposition in adult courts. In contrast, none of the IST children had been incarcerated for extended periods of time, and none were in adult facilities.

Figure 2
Recorded Arrests per 1000 Youth by Group and Pre/Post FIAP Time Period



Note. The U.S. and Florida juvenile case rates are noted at the right.

Permanency Placements and Delinquency

The effect of placement into an adoptive home or reconciliation with biological family was of great interest in this study, because permanency planning is a major focus of the project. By March of 1993, approximately 25% of both groups were living with biological families or in adoptive homes. Although the numbers of children with delinquency histories in the permanency homes were too small for statistical analysis, some current trends are interesting and encouraging.

When comparing case rates for children in permanent homes, SP children apparently had much less history of juvenile delinquency prior to the FIAP study than those in IST (a case rate of 1000 for SP compared with 2889 for IST). This suggests that the children in SP for whom permanent placements were achieved were those with minimal anti-social behavior, while the IST program seemed to be willing to integrate youth with more serious delinquency histories into permanency settings. Nevertheless, the delinquency case rate for IST children in permanent placement decreased to about 40% of the earlier rate while in foster care, while that for SP remained constant. For children still in foster care placements, the case rates for both IST and SP remained stable.

Discussion

Several factors found in previous research to be correlated with risk of delinquency relate to the differences expected between the IST and SP groups. The IST model is strongly family focused, with case loads and the structure of services allowing intensive needs assessment with all key players involved with each individual child and family, including foster families. A family systems approach is used that emphasizes empowerment of the biological, adoptive, and foster care families, and an integrated system of service delivery that is highly individualized (wrapped around children *and* families) and family focused. A conscious goal of the IST model is to encourage healthy bonding with biological families, when appropriate, even for children placed for adoption, and to provide in-home services designed to improve family capacity to resolve conflicts, cope with behavioral problems, and make constructive use of social and mental health services as needed.

Although most juvenile delinquents do not become criminals as adults (Schorr & Schorr, 1988), the markedly higher delinquency case rates in this sample of multi-problem children in foster care suggests that outcomes for them may not be as optimistic. The proportion of more serious crime (felonies and sexual offenses as opposed to misdemeanors), the progression to adult courts and prisons, as well as the higher proportion of violent crime versus property offenses, when compared with general population figures, suggests that these children are at higher risk for continued legal problems than juvenile delinquents in general.

The cost of incarceration in high security detention has risen to $85 per day (Myers & Fletcher, 1993), and the social cost of delinquency is very high, even without considering those who will continue criminal activity as adults. This study suggests that foster care youth with emotional and behavioral disabilities show a much higher prevalence of delinquency than Florida youth in general. The results to date also suggest that the family-oriented, individualized intervention used in this study has significant potential for reducing the high human and economic cost of delinquency.

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Using Aggregated Progress Indicators to Evaluate Treatment Foster Care: Replication of a Statewide Study

Evaluations of individualized services such as treatment foster care usually have been conducted on a case-by-case basis. In this study, we analyzed aggregated Progress Indicator (PI) data for a group of 46 children to determine behavioral trends over their first year in treatment foster care. PIs included school nonattendance, temper outbursts, assaultiveness, sexual acting out, and enuresis. Consistent with previous findings, these results indicated that assaultiveness and sexual acting out significantly decreased, but not until the ninth month of treatment. Results also indicated that treatment progress followed a linear course, with no discernible "honeymoon" or problem exacerbation phase. Finally, age and diagnosis predicted problem severity, but gender did not. Recommendations for foster parents, researchers, and policy makers are provided.

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Introduction

Therapeutic foster care, one of the least restrictive type of residential placement for children with severe emotional disturbances, is increasingly being used (Friedman, 1988), but very little evaluation data are available which assess its effectiveness. The uniqueness of each placement experience to each child, a major benefit of therapeutic foster care, is also the reason it is difficult to evaluate.

Progress Indicator (PI) tracking was introduced by VanDenBerg in the evaluation of individualized services in the Alaska Youth Initiative (VanDenBerg, 1990), and the use of PIs was refined and expanded by Burchard in the evaluation of individualized care alternatives in Vermont (Burchard & Clarke, 1990). In the state of Washington, all clients in the Children's Hospital Alternative Program (CHAP), a treatment foster care option sponsored jointly by the state Division of Mental Health and Division of Child and Family Services, are tracked daily by their foster parents on five standard and two individualized PIs. The standard PIs, selected by consensus of mental health administrators and evaluators are: school non-attendance, temper outbursts, assaultive behavior, sexual acting out, and enuresis.

In 1991 we examined the progress of 26 CHAP children by analyzing six consecu-tive months of data on the five standard

PIs. Significant behavioral improvements over time were seen for all PIs except temper outbursts. In addition, we noted that the pattern of improvement appeared to be curvilinear, with behavior problems increasing in the first five months (i.e., a "honeymoon effect"), and then beginning to decrease by the sixth month. These preliminary findings led to the following research questions regarding therapeutic foster care:

1. Do problem behaviors significantly decrease over time? If so, when?
2. Is the treatment pattern curvilinear?
3. Do problem behaviors and treatment progress vary systematically by age, gender, and/or diagnosis?

Method

Subjects

Because relatively little information is available which describes treatment foster care populations, we will present descriptive information for our total sample of CHAP children, as well as for the subsample whose data were analyzed in the present study.

Total Sample

Descriptive data are provided for children who were residing in CHAP homes in 1990 and for all new admissions through mid-1991, a total of 299 children (63% male). Age at admission ranged from 1.5 to 17.0 years, with a median age of 12 years. Three-quarters of the youth were Caucasian, 13% African-American, 4% Native American, and 4% Hispanic. At the time of admission, 36% were in behavior disorder classrooms, and 29% were in learning disabled classrooms. More than one-third (36%) were academically delayed by one or more grade levels.

Only 11% of the children were in the custody of their parents or other relatives at the time of placement. Over half of the children were having contact with their families less frequently than once a week. The majority of the youth came from households where they had suffered neglect, abandonment, and/or abuse. Ninety-nine percent of the children had had prior out-of-home placements, with a median time of 19 months out-of-home. Two-thirds of the children had been in regular foster homes within the six months prior to CHAP placement. Of the 73 children discharged during the study period, the median length of stay was 19 months. Most of the children had received a DSM-III-R diagnosis (see Table 1).

Table 1
DSM-III-R Primary Diagnoses of Total CHAP Sample
(*N* = 299)

Internalizing Disorders	
PTSD	16%
Adjustment Disorder	6%
Major Depression/Bipolar Disorder	7%
Dysthymia	7%
Attachment Disorder	3%
Anxiety Disorder/OCD	2%
TOTAL	41%
Externalizing Disorders	
Conduct Disorder	18%
Oppositional Defiant Disorder	15%
Attention-deficit Hyperactivity Disorder	9%
Drug Abuse	1%
TOTAL	43%
Other Diagnoses (PDD, MR, Schizophrenia) = 16%	

Present Sample

Because we were interested in describing children's treatment progress temporally, we included in the present study only those children whose PI tracking had begun within three months of their placement in CHAP homes and who had at least six months of PI data. This process yielded a sample of 46 children (23 male and 23 female). Thirty-two of these children also had data through 9 months, and 13 had data through 12 months. The children ranged in age from 3.0 to 16.5 years, with a mean age of 11.7 years. The most common diagnoses were Post Traumatic Stress Disorder (PTSD) (30%), Conduct Disorder/Oppositional Defiant Disorder (ODD)/Attention Deficit Hyperactivity Disorder (ADHD) (28%), and Dysthymia (17%).

Measures

Each child was tracked on the five standard PIs as well as two individualized progress indicators (IPIs) that were selected by foster parents and case managers. Each foster family was trained in the PI tracking procedure and provided with daily PI tracking sheets and behavioral descriptions of PIs. Data were collected in terms of number of days that the PI behavior occurred.

Results

Do problem behaviors show a significant decrease?

Children who did not display a particular problem behavior in the first 6 months of placement were excluded from analyses of those behaviors. For example, only 20% of the sample averaged at least one episode of sexual acting out per month in the first 6 months of foster care, and only the data for those children were examined for that variable. When the children for whom the problem behaviors were relevant were compared via t-tests (see Table 2), results indicated that half of the behaviors (i.e., assaultiveness, sexual acting out, and individualized PIs) significantly decreased at the .05 level from Time 1 (months 3 + 4 + 5) to Time 3 (months 9 + 10 + 11). The other behaviors measured—nonattendance, temper outbursts, and enuresis—did not change for the total sample.

Table 2
Frequency of PIs at Time 1 Versus Time 3

PI	*N*	Frequency Time 1	Frequency Time 3
Nonattendance	26	2.3 (1.7)	3.5 (6.0)
Assault	21	6.1 (6.2)	3.9 (5.5) *
Temper Outburst	34	7.0 (5.6)	6.9 (5.0)
Sexual Acting Out	8	2.8 (2.6)	.9 (1.0) *
Enuresis	9	3.8 (1.9)	4.1 (6.1)
IPI #1	46	9.7 (8.5)	10.9 (9.2)
IPI #2	46	10.5 (8.7)	8.0 (7.9) *

Note: Time 1 = Means and (Standard Deviations) of number of days per month the behavior occurred for months 3, 4, and 5.

Time 2 = Means and (Standard Deviations) of number of days per month the behavior occurred for months 9, 10, and 11.

N = number of children displaying behavior at Time 1.

* *Indicates significant difference at the one-tailed .05 level.*

Is the pattern of treatment progress curvilinear?

Because foster parents varied with regard to when they began tracking PI data, we were not able to assess behavior changes in the first two months of placement, but t-tests comparing Time 1 (months 3 + 4 + 5), Time 2 (months 6 + 7 + 8), and Time 3 (months 9 + 10 + 11) failed to yield evidence for a "honeymoon" period. That is, for no behavior was there a significant increase at Time 2 or Time 3 above that which was obtained at Time 1. Although individual children showed fluctuations in behavior rates, the general trend was linear and negative, suggesting a decrease in problem behaviors beginning at months nine through eleven.

Do PIs and treatment progress vary by age, gender, or diagnosis?

At Month 3

Backward stepwise multiple regression analyses were conducted using age, gender, and diagnosis (i.e., internalizing and externalizing) as independent variables and PIs as dependent variables. Results indicated that 10-33% of the variance in the five standard PIs was accounted for by age (see Table 3). Younger children were found to display higher levels of assault, temper outbursts, sexual acting out, and enuresis, whereas older children had higher levels of school nonattendance. Surprisingly, neither gender nor diagnostic category predicted behavior levels.

Table 3
Results of Multiple Regression Analyses Using Age, Diagnosis, and Gender to Predict PIs at Month 3.

PI	Adjusted R^2	F	p
Nonattendance Age	.13	7.48	.009
Assault Age	.33	22.83	.000
Temper Age	.19	11.55	.001
Sex Acting Out Age	.17	10.00	.003
Enuresis Age	.10	6.19	.017

df = 3,42

At Month 10

Multiple regression analyses computed at ten months indicated that the effects of age had disappeared, with the exception that sexual acting out and enuresis remained more common in younger children. Age accounted for 14% and 18% of the variance in these behaviors, respectively. Diagnostic category accounted for significant proportions of variance in temper problems (8%) and IPIs (15%) in the following manner: externalizers showed greater temper problems, and internalizers showed higher levels of problem behaviors on their IPIs. Gender remained unpredictive at month 10.

Treatment Course

Logistic regression equations were computed to predict clients' overall status (i.e., improved, not improved) on each PI, again using age group (11 or younger, 12 or older), gender, and diagnostic category as independent variables. Perhaps because of small sample size, prediction of improvement status at a rate better than chance was not possible.

Conclusions

The severe problem behaviors of children in therapeutic foster care homes never worsened beyond Time 1 (e.g., month 3), and half of the behaviors measured began to improve by months 9-12. Those behaviors which significantly improved included assaultiveness, sexual acting out, and individual progress indicators that the foster parents selected.

The five standard progress indicators appeared to be more relevant to younger children. School nonattendance was the only standard progress indicator measured that was more relevant for older children. Individualized PIs could not be analyzed in the aggregate because they necessarily differed for each child. Nonetheless, PIs appeared to be more sensitive to the particular manifestations (e.g., self-deprecating remarks) of problem behaviors of children with internalizing disorders.

Perhaps because of small sample size, efforts at predicting the treatment course by gender, age, or diagnostic category were not successful. In general, females in this sample appear to be quite comparable to males. It should be noted that, because of the small sample size, the findings of this study must be considered preliminary and can not necessarily be applied to all the general therapeutic foster care population.

Recommendations

Foster Parents

These findings suggest that foster parents should expect younger children to have more problems with assault, temper, sexual acting out, and enuresis. They can expect older children to have more problems with school nonattendance. Overall, sexual acting out is rather uncommon (20% of children), whereas temper outbursts are quite common (76%). Expect limited improvement in any behaviors until approximately months 9 - 12.

Policy Makers

These results appear to lend support for the value of long-term foster care as a stabilizing environment. Plan to provide extra support to foster parents during the first 9 months to boost morale and prevent burnout.

Treatment Evaluators

1. Take special efforts to train parents and case managers in data collection techniques. For example, explain that changing IPIs in mid-treatment without informing the researchers invalidates those data. Encourage prompt identification of individualized IPIs and commencement of tracking to avoid lagtime and to allow for better evaluation of the earlier stages of treatment. If possible, also encourage parents to track confounding events (e.g., illnesses, losses) which might impact behavior.
2. Provide foster parents and agencies visual feedback of their tracking to serve as a motivator and a clinical tool for them.
3. Continue tracking through at least one year, as improvements generally do not appear to begin until then.
4. To avoid analyzing data with a skewed distribution, exclude from analyses particular IPIs which are not relevant for particular children. Regularly reassess the relevance of the selected IPIs to the treatment population.
5. Continue to use IPIs as a more sensitive measure of the problems of older children and children with internalizing disorders. Alternatively, standard progress indicators which reflect characteristics of internalizers (e.g., sad mood) could be used.

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Research in a Public Welfare Agency: Integrating Research into Practice

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This paper presents information about a public agency-based research center. The operating principle of the research center is data-based organizational change. Evaluation and research conducted in the center is both formative and summative and can impact both program operation and policy.

The paper addresses funding mechanisms, staffing, organizational structure, and also, the integration of findings into practice. Examples of research projects currently in process are included. Finally, the paper discusses how research questions are developed and implications of the selection of outcomes.

Introduction

Research and evaluation of program and policy issues can contribute to the improvement of public agency services to children. Research on the identification of risk factors associated with child abuse and neglect, assessments of level of readiness for independence of children in foster care, and identification of effective intervention strategies and characteristics of juvenile offenders who recidivate are all examples of information that can provide a foundation for data-based organizational, program and policy change.

Data-based organizational change is the focus of the Office of Children's Administration Research (OCAR). OCAR is a research center located in a public welfare agency in Washington state. OCAR is currently involved in 15 research and evaluation projects with a total of 22 full-time research, computer and clerical staff. Through a variety of Federal and State grant initiatives, OCAR conducts research and evaluation projects on various policy and program questions related to the Division of Juvenile Rehabilitation (juvenile incarceration and parole) and the Division of Children and Family Services (child protective services, foster care and adoption services).

The organizing principle defining OCAR's approach to research and evaluation is that administrators, program managers, legislators and the community need information on which to base policy development and to guide program change. While there are researchers in academic settings and private agency settings who conduct research that is of interest and value to public welfare administrators, the primary thrust of much of the academic research is related to "basic research," e.g., theory development, theory testing, or "knowledge gain." Private agency researchers are most likely to be engaged in research specific to the program in which they work for the purpose of improving their program. The guiding principle of data-based organizational change (DBOC), at least in this context, is that the research and evaluation findings should have direct or applied relevance to the delivery of social services in public (or private) child welfare agency settings, and to policy guiding those programs.

The following is a sample of the research and evaluation projects currently in progress in OCAR:

1. *Risk Assessment* - an ongoing evaluation of the implementation of risk assessment in child protective services. Questions include whether the model improves the quality and consistency of child protective services assessment and service delivery.
2. *Independent Living* - a needs assessment of adolescents in foster care over age 16 who are unlikely to be reunited with their parents. The study examines the skill level of adolescents and their ability to live independently.
3. *Sexually Aggressive Youth* - a project to identify the number of youth on current active child welfare caseloads who meet specific definitions of sexual aggression, including a description of their characteristics and service needs.
4. *Placement Reunification* - a study to examine factors which differentiate successful versus unsuccessful reunification of families with their children who have been in out-of-home placement.

How are research questions developed?

The scope and nature of any research project entering OCAR is set by the funding source. In terms of the federally funded research projects, the Federal Register lists topics of interest for the respective funding agency, or the "field" can initiate topics of interest. Federal child welfare research monies are available from such entities as the National Center on Child Abuse and Neglect, the National Institute of Mental Health, and the National Institute of Justice among others. (A less common but possible source of research funding is through private foundations interested in child welfare issues.)

A second source of funding for OCAR research is the Washington State Legislature. In our state, when the Legislature funds a new program, there is usually interest in determining if the program accomplished the intended outcomes. While the questions that are addressed in federal and state funded research studies are generally stipulated by the funding source, we may include additional questions that are of specific interest to the program in which we are conducting the research.

A third source of funding for OCAR is a biennial "base" budget set aside by the Department of Social and Health Services for research and evaluation of programs within the Division of Children and Family Services and the Division of Juvenile Rehabilitation. The research can be either formative or summative depending on the designated project. Generally, at the beginning of the budget cycle, meetings are held with administrators regarding the projected research or evaluation activities for the following two years. In addition to the "base" funded evaluations, individual programs can "contract" for specific projects of interest.

To date, much of the activity of OCAR has been focused on establishing baseline information against which program effectiveness can be measured. While some states have extensive information systems, the majority do not. Washington State is in the process of establishing a new management information system; however, that system does not yet provide sufficient information to measure change in clients requesting and receiving services, or outcomes for clients who are served within the public agency system.

Our experience indicates that identifying outcome measures to assess public agency program effectiveness is not a simple process. For example, take "re-referral" as an outcome for the effectiveness of intervention in child protection. Do we count any new referral to the agency post case closure or only substantiated re-referrals? What if there is a new incident of child abuse and neglect on a different child in the family? Is that a successful outcome (in terms of the sibling who was not maltreated in the new incident) or an unsuccessful outcome (in terms of the parent, who maltreated again)? How does a new referral of less severity get evaluated? These kinds of distinctions may seem trivial, but can have a significant effect on the interpretation of successful program outcomes. These kinds of distinctions can be drawn for any known outcome measure currently used in child welfare outcome research. In fact, much of the current debate on program effectiveness, for program innovations in the 1980's, is that the outcomes utilized in the evaluations were not the "correct" ones, or were not correctly specified. It is critical, as we begin to develop outcome measures in child welfare, that we have a dialogue about the definition of "outcomes" so that we can compare outcomes across programs and between programs. Attempts to simplify the issues only dilute the complexity of the problems dealt with by public child welfare agencies.

How are the research projects staffed?

There are a variety of job functions within the Office of Children's Administration Research. These job functions include a Director, Research Managers, Computer Information Consultants, Research Analyst/Data Collectors, Accountant, and Clerical Support. Consultants are hired for specific tasks around data analysis or research design.

Relationship to the Organization

The Office of Children's Administration Research was initially assigned within the administrative structure of a division responsible for children's programs within a layer of the Department of Social and Health Services. As the scope of the office expanded, a decision was made to place OCAR outside the administrative structure of the programs being evaluated. OCAR was organizationally placed within a separate division that housed other administrative structures like budgeting and computer systems. Eventually, OCAR was moved into a separate administrative structure of its own with direct reporting authority to an Assistant Secretary of the Department. The purpose of these administrative changes was to remove oversight from the Division structure in order to improve the real and perceived ability of OCAR to provide objective, unbiased analyses and findings. The second goal in changing the "reporting" authority of OCAR was to provide a more direct link between the data developed and the policy makers at the executive level of the agency.

In addition to refining the position of OCAR in terms of reporting authority, the physical location of the office was separated from the administrative offices of the programs. Again, the purpose of the separation was to promote objectivity. The research staff involved in administrative policy and programs discussions were "psychologically" distanced from the program by being physically located in a different building.

How are the data integrated into program and policy decisions?

There are a variety of ways to integrate data into both program and policy decisions. Information about outcomes or process evaluations can improve contracts with providers. Local administrators can use information about their office's clients to inform local providers and to guide resource development in the direction of identified client needs. Sometimes data can support a decision that certain services, or a particular policy is not needed.

Data from some of the OCAR projects have been used to persuade legislators to fund enhanced programs for a specific population of youth, e.g., enhanced treatment resources for *both* sexually aggressive youth *and* for victims of sexual aggression. On occasion, data from applied-oriented research projects have been used to support Federal policy, e.g., research on risk assessment and family preservation. Lastly, data from program level research projects can be used to inform policy makers and administrators through dissemination in national conferences or journal publications.

While all of the above methods enhance the likelihood of the integration of findings into the practice, the primary purpose of the research is to improve the lives of children and families by improving policies and programs that address human service needs.

Characteristics of Children Receiving Services

Chapter 6

A System of Care for At-Risk Infants and Their Families

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This paper presents preliminary results from a study of the effects of a training program for community service providers and lay helpers. The major purposes of the training program are to enhance the trainees' understanding of infant mental health principles and practices, increase early identification and referral of at-risk infants, and strengthen networking within the community. Results reveal a significant increase in referrals following the initial set of training sessions. The percentage of live births referred in the intervention site was significantly greater than the percentages in the two control sites. Results are discussed as they relate to the development of a system of care for at-risk infants and their families.

Introduction

Mental health problems in young children are often associated with earlier disturbances in the caregiver-infant relationship (Sameroff & Emde, 1989). Therefore, efforts to prevent the development of emotional and behavioral problems in young children need to begin in infancy. This paper reports preliminary results from a research and demonstration project designed to test strategies for utilizing existing community structures as the foundation of a system of care for infants who are at risk for mental health problems. The existing structures are primarily those created to implement the provisions of Public Law 99-457, the Education of the Handicapped Act Amendments of 1986.

In 1986, Public Law 99-457 was passed by the U.S. Congress. This law mandated services for children with disabilities ages 3 to 5 years and gave states the option of providing services to children ages birth to 3 years, including children who are at risk for various disabilities. North Carolina, as well as several other states[1], initially took this option. North Carolina already had several early intervention programs serving the birth to 3 population. This law and the federal funding which it engendered enabled the state to provide these services statewide.

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[1] The number of states and territories who say that at-risk infants and toddlers are eligible for Part H early intervention services in their state or territory has varied from year to year. The latest information from the National Early Childhood Technical Assistance System (NEC-TAS) indicates that 12 states (Arkansas, California, Colorado, Hawaii, Indiana, Louisiana, Massachusetts, Michigan, Mississippi, New Hampshire, New Mexico, north Carolina) and two territories (Guam and the Virgin Islands) say that they have adopted the at-risk option (Evelyn Shaw; personal communication, October 25, 1993). States and territories vary greatly, however, in the risk factor (parental developmental disability) and Louisiana includes only child biological risk factors. On the other hand, some states/territories that say they do not include the at-risk population list eligibility criteria which in fact include risk factors. For instance, in American Samoa infants of mothers with AIDS, substance abuse problems, or various other medical conditions are eligible and in Rhode Island, infants whose families have four or more child and/or family risk factors are eligible.

Several features of Public Law 99-457 and of the structures developed to implement it in our state create opportunities for building a system of care for at-risk infants and their families. The law requires assessments of the needs and strengths of the family as well as of the child and development of an individualized family service plan. This affords the opportunity to provide services to families to alleviate factors that place their infants at risk for mental health problems. The law requires a state-level interagency coordinating council. In our state this generated the development of local interagency coordinating councils which can provide the foundation for the development of local systems of care. As noted above, the law also provides the opportunity to receive federal assistance to serve infants and toddlers who are at risk for developmental disabilities, including mental health problems.

In 1987, North Carolina adopted "at risk for atypical development" as one of its eligibility categories in the infant/toddler program. Under this category, infants and toddlers who are at risk for mental health problems are eligible for early intervention services. Traditionally, early intervention programs had focused on infants and toddlers who had, or were at risk for cognitive, sensory, and motor disabilities (e.g., medically fragile children and children with Down syndrome, cerebral palsy, spina bifida, visual impairments). Although some of these children might also have been at risk for development of emotional problems, this was not a major focus. Biologically intact children who were at risk for mental health problems due primarily to environmental factors were usually not served by these developmental disability programs. The new eligibility category, at risk for atypical development, enables early intervention programs to begin serving these environmentally at-risk infants and toddlers. The research and demonstration project is studying the system of care for this at-risk population.

The project consists of two intervention studies, a community-level study and a family-level study. The aim of the community-level intervention study is to test the efficacy of community intervention for increasing the early identification and referral to the early intervention program

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Several people made important contributions to this study. Judith Nebrig, in her role as director of the Family Resource Program, served as director of both the community-level and family-level intervention programs. She and Geofrey Bullock, program coordinator, designed and conducted the community-level training programs and were the major link with the community service providers as well as important sources of creativity and inspiration for the project. Wendy Jodry, research coordinator, Linda Burrell, Kristen Migliaccio, Pat Lockwood, and Mae Sisk collected, coded, processed and analyzed the data. Olivia Carswell, Pat Lockwood, and Mary Sisk provided clerical support for the study. Dr. Lenore Behar and Susan Robinson in the state office provided much needed administrative support. A special word of appreciation goes to the intervention staff, service providers, and community members who took time out from their busy lives to complete the forms and questionnaires for the study.

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of infants who are at risk for mental health problems. The aim of the other study is to test the efficacy of the family-focused, home-based intervention program for promoting the mental health of these at-risk infants. This paper presents preliminary results from the community-level intervention study. Specifically, the goal of the community intervention is to increase the number of infants age 6 months and younger who are identified and referred to the early intervention program. It was determined that if people in the community were going to identify and refer these infants and their families, they needed to know: (a) who to refer (i.e., how to identify the infants at risk), (b) how to refer (i.e., the specifics of the referral process), and (c) why they should refer these families to the early intervention program. The major strategy for addressing these issues is a series of training sessions for members of the two counties served by the early intervention program.

Method

Subjects

Subjects in the community-level intervention study's Time One assessments included 128 service providers (e.g., child protective service workers) and other community members (e.g., workers in church-sponsored programs which serve high risk families) who had opportunities for identifying and referring at-risk infants and their families at three different sites (an intervention site and two control sites). Each site consists of a two-County area served by a state- and federally-funded early intervention program. The three sites are fairly similar in population size (ranged from 97,125 to 134,848) and demographics (e.g., mean per capita income ranged from $11,107 to $13,219; school dropout rates from 4.5 to 5.8). One control site is served by an early intervention program trained under a Child and Adolescent Service System Program (CASSP) to serve infants and toddlers who are at risk for mental health problems (the CASSP control site). The other control site has the option under state guidelines for serving this population, but no specific training to do so (the non-CASSP site). The early intervention program at the intervention site had also received the CASSP training. The community members who were asked to participate in the study were identified by the early intervention program staff in their community as being people who have significant contact with infants and their families. The goal was to include lay helpers in the communities as well as traditional agency personnel.

Intervention

The major community-level intervention is a series of training sessions provided in each of the two counties in the intervention site. The main objectives of the sessions are to provide training in: (a) how to identify factors which place infants at risk for mental health problems, (b) how to refer infants and their families to the early intervention program, and (c) why intervention which is family-centered and which begins during early infancy is the treatment of choice for at-risk infants.

Initially, a series of quarterly training sessions were planned. After the first session, some of the trainees requested more frequent training, so monthly seminars were provided in between the quarterly trainings. The seminars focused on issues raised by the trainees (e.g., drug-exposed infants, nurturing parents, multiple caregivers).

Data Collection

Data are collected from community members at each site regarding their referrals to the early intervention programs of at-risk infants age 6 months and younger. The person taking the referral documents the risk factors spontaneously named by the person making the referral and then asks about the presence or absence of each risk factor that was not mentioned spontaneously. In addition to collecting this information regarding post intervention referrals at each site, the number of at-risk infants age 6 months and younger who were referred at each site during the 12 months prior to onset of intervention was recorded.

There are four categories of risk factors: (a) *child characteristics* (low birth weight, prematurity, atypical patterns of feeding or sleeping, developmental delay or disability); (b) *parent characteristics* (substance abuse, mental illness, mental retardation, teen parent, history of being maltreated); (c) *environmental* factors (limited social support, lack of stable housing, low socioeconomic status); and (d) *caregiving factors* (no well-baby care, difficulty in parent-infant relationship, lack of basic care, suspected maltreatment). The first three sets include factors that may make it difficult for a parent to provide the kind of care and nurturance needed to promote healthy infant development. The care-giving factors are all indicators that the infant is not receiving the kind of care he or she needs.

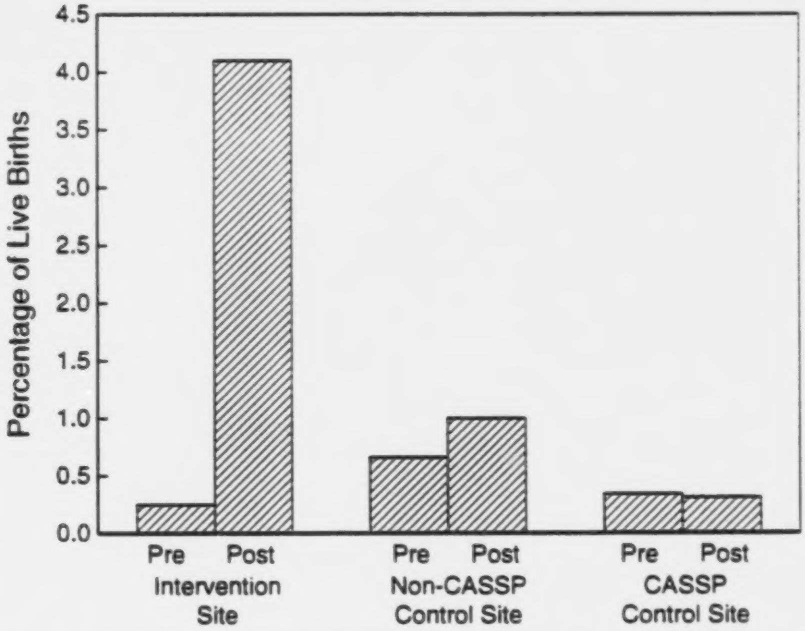
Results

Since the three sites differed somewhat in population (i.e., ranged from 97,125 to 134,848), the number of referrals per year was calculated as the percentage of live births at each site. Results show a dramatic increase in the percentage of live births referred for early intervention at the intervention site. Following intervention, the intervention site had a significantly greater percentage of live births (4.09%) referred for early intervention than did either of the two control sites (1.04% at non-CASSP control site; .31% at CASSP control site). The pre-post increase was also significantly greater for the intervention site (Results are presented in Figure 1).

At the control sites, child characteristics were mentioned as risk factors for significantly larger percentages of referrals than at the intervention site. Parent characteristics such as substance abuse and mental illness were spontaneously named for a significantly greater percentage of the referrals at the intervention site than at the CASSP site. These results suggest that the training may have been effective in helping the people making the referrals at the intervention site understand that these parent characteristics place the infant at risk for mental health problems and that the early intervention program can address these issues (Results are presented in Figure 2).

Figure 1

Pre- and Post-intervention Percentages of Live Births Referred for Infant Mental Health Intervention by Age 6 Months

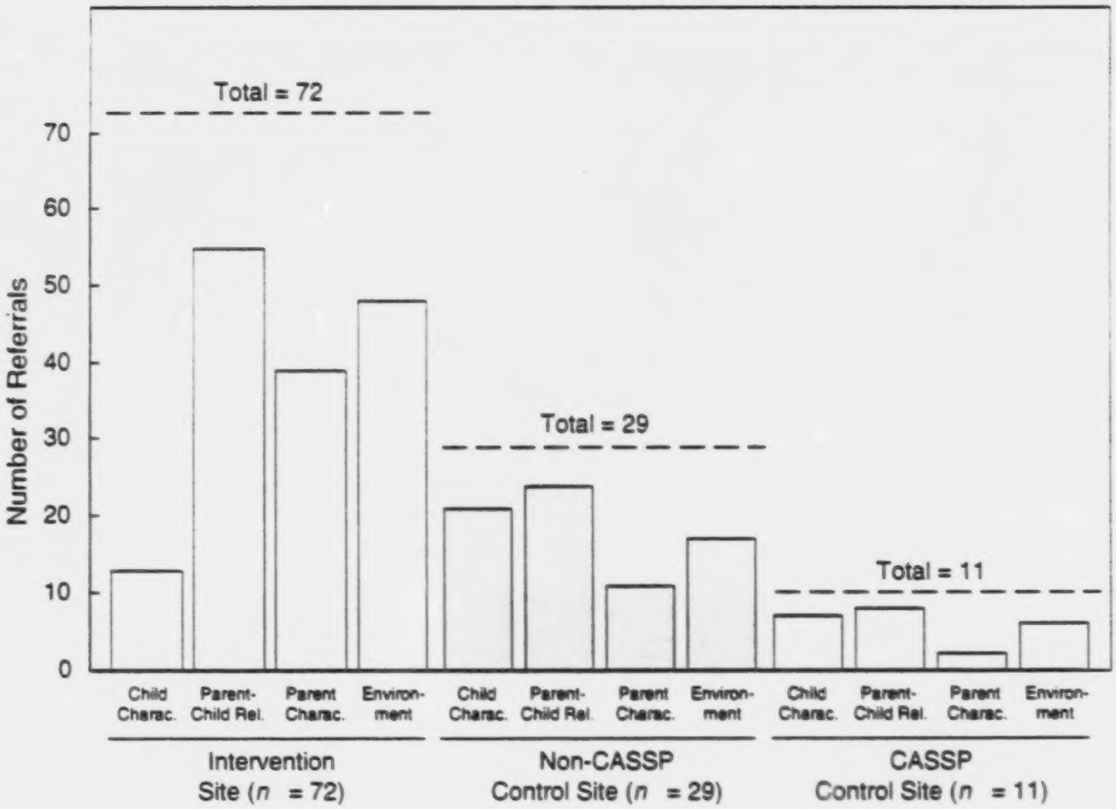


Conclusions. The community-level intervention which was tested in this study was one which targeted a broad spectrum of people in the community and provided in-depth training on factors that place infants at risk and the kinds of treatments needed by these infants and their families. The results suggest that an intervention of this type can be successful in raising the consciousness of community members regarding infant mental health and in increasing the early identification and referral to early intervention services of at-risk infants and their families.

This is the first step in building a system of mental health care for at-risk infants and their families in this community. An adequate system of care for these multi-need families requires the collaboration of a number of sources of support within the community. One outcome of the training sessions and seminars has been increased networking of agencies and groups which provide resources for high-risk families. The next step is to study strategies which enable this network to provide services which are better coordinated, more accessible, and more attuned to the principles and best practices of infant mental health.

Figure 2

Number of Spontaneously Named Risk Factors by Risk Category and Site



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Children Who Sexually Abuse Other Children: Research Findings From Three Studies

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This paper presents some exploratory descriptive data on the characteristics of children who sexually abuse other children. Data on youth and family demographics, offender and offense characteristics, victim characteristics and service outcomes were collected in three studies over a five year period. The most striking findings are the numbers of youths who are sexually aggressive, the magnitude of their behaviors, and the frequencies of both male and female victims. The youths themselves were found to be victims of multiple types of abuse and were often on public agency caseloads for their own protection. The youths were not often held accountable for their behaviors in the juvenile justice system.

Introduction

Within the client population of public child welfare agencies, there is a sub-set of children who sexually abuse other children. These children and their families present social workers with special challenges in case planning and service delivery. This paper provides an overview of data collected from three research studies conducted since 1987.

Demographics, Characteristics & Service Outcomes

In 1987, an exploratory research project on sexually aggressive youth (SAY) was conducted to determine descriptive demographics, offender and offense characteristics and service outcomes. In a five county catchment area, 75 youths were identified as having committed sexually aggressive acts toward other children. To be classified as sexually aggressive, there had to be a three year age differential between the aggressor and the victim, the act had to be non-consensual and intrusive. Standard legal definitions of rape, molestation and indecent liberties were used. During this exploratory study, it was learned that these youths were known to have sexually abused at least 150 children. The average age of the victims was between ages three and five, while the average age of the perpetrators was fourteen to fifteen. Less than 50% of the perpetrators were prosecuted, primarily because the victim was too young to testify (McKenzie, English, Henderson, & Tosti-Lane, 1987). Utilizing a risk assessment model developed from a review of the literature, it was found that youths considered highly likely to reoffend were left in homes with potential victims, and youths with an assessed low likelihood of reoffending were placed in foster care (McKenzie, et al., 1987).

In response to the 1987 study's findings, a case management model was developed, caseworkers were trained in issues related to sexually aggressive youths, and monitoring of case practice was instituted in this five county area (Henderson, English, & McKenzie, 1988).

Based on the original study, it was estimated that there were approximately 600 sexually aggressive youth on public child welfare caseloads in Washington state.

In 1989, the Washington State Legislature passed legislation called the Community Protection Act, which increased the penalty for sexually offending behavior, provided treatment resources for high risk sexually aggressive youth and provided additional resources for the treatment of victims of sexual abuse. In October, 1990, public agency caseworkers were asked to identify any sexually aggressive youth (SAY) on their caseloads who met the legislative definition of eligibility for the additional treatment funds. In order to be eligible, the case had to be open and active, the SAY had to have been victims of child abuse and neglect themselves, and they had to have committed a sexually aggressive act. Sexually aggressive was defined to include both aggression and sexual behavior. Sexually aggressive behavior included sexual contact, such as touch of genitals or intercourse, and aggressive was defined as physical force used to accomplish the act. Coercion, which included direct implied threat or inequality in size, age, development, or deception was also included in the definition.

A total of 642 SAY were identified, and a random sample of 200 SAY were selected from the total for extensive case review. Eighty-eight SAY referred and approved for special treatment were also included in the sample. The comparison of interest in this paper is age: SAY were sub-divided into two groups younger (ages six to twelve) and older (ages thirteen to eighteen). For this analysis, there are 89 SAY under age twelve, and 182 SAY over the age of twelve. This breakdown between the two groups was proportionate to the two groups' presence in the overall population of identified youth (English, & Brummel, 1991).

The data on characteristics of sexually aggressive youth included a description of their families, risk factors, sexually offending and other behaviors, victim characteristics, and services authorized. This paper will conclude with a discussion of the policy and practice implications for this data. The following is a summary of the findings from the second study conducted on SAY:

- 67% of SAY statewide were over the age of 12.
- 87% were males.
- 19% of the younger SAY were females; 9% of the older SAY.
- Ethnicity was evenly distributed between age groups.
- There were nearly three times as many African Americans in the under age twelve group. There was a high percentage of children of color identified as SAY compared to their representation within the community at large.
- Younger SAY had a high number of disturbed behavior histories, particularly those related to bodily functions, i.e., enuresis and encopresis.
- 96% of younger SAY were identified as victims of multiple types of abuse; 71% of the older SAY were identified as victims of multiple types of abuse and 12% were identified as victims of sexual abuse alone.

- 89% of younger SAY entered public agency programs through Child Protective Services (CPS) compared to 56% of the older SAY; 28% of the older SAY also entered through Child Welfare Services (CWS); 69% of both had prior public agency contact.
- 81% of the younger SAY were in temporary public agency custody compared to 56% of the older SAY.
- Two-thirds were never charged for SAY behaviors; the other third were either reduced in number of offenses charged, or offenses were reduced to lesser included offenses.
- Younger SAY were responsible for 1,058 incidents of sexual aggression compared to 2,887 for older SAY. This was an average of twelve incidents for younger SAY, sixteen for older SAY.
- 65% of older SAY victimized at least one male child and 76% at least one female child. Younger SAY did not appear to select female victims over males.
- 83% of younger SAY were placed for their own protection, compared to 42% of older SAY; 90% of older SAY were placed due to a need for supervision.
- 63% of younger SAY received victim oriented assessments compared to 34% of the older SAY; 73% of the older SAY received offender assessments compared to 49% of the younger SAY.

In addition to demographic data, data on risk factors associated with sexual aggression in youths were also collected. In the first study, a risk assessment matrix identifying family risk factors, youth risk factors and victim risk factors was developed (See Table 1 for a list of the 32 risk items included in the SAY Risk Model). A comparative analysis of risk factors by age of SAY was conducted, as shown in Table 2.

There were significant differences in the risk factors that were found to be important by age of child perpetrator. Six out of twelve family and environmental risk characteristics were significant for the younger SAY. In contrast, nine out of fourteen SAY characteristics were significantly associated with the older SAY. Three out of six victim risk factors were also significantly associated with the older SAY. Overall, younger youths were assessed as moderately likely to reoffend (84%), although preliminary follow-up data indicate 88% did exhibit sexually aggressive behaviors while in placement. Twice as many older youths were predicted to reoffend, but reoffense reports were not significantly different for the older youths. This data are preliminary at best, and additional work on the validation of the Sexually Aggressive Youth Risk Model is being conducted.

Summary and Conclusion

This evaluation is descriptive and formative in nature. The purpose of the evaluation was to provide public agency administrators and direct line practitioners with information about the characteristics of the sexually aggressive youth served on public agency caseloads, and to provide some preliminary information on case management practices related to younger versus older sexually aggressive youth. Outcomes related to the provision of treatment to SAY were not evaluated in this research. An additional study would need to be conducted to examine long term outcomes for these youths. The data collected in this project could serve as a baseline for such an evaluation.

The children in this study have troubled behavioral histories, and families with serious functional deficits. They continue to exhibit serious dysfunctional behaviors while in the care and custody of DCFS. *All* of the youth identified in this study met the eligibility criteria for specialized treatment resources, but only 13% were referred for services during the first year. That does not mean that these children were not referred for services; all of them were receiving some type of intervention. The question is whether the intervention was appropriate, and/or whether or not it was sufficient to contain and/or eradicate sexually aggressive behavior (English & Brummel, 1992).

Table 1
Sexually Aggressive Youth Risk Assessment Guidelines
Assessment Categories

A. Family and Environmenta Characteristics	B. Sexually Aggressive Youth Characteristic	C. Victim Vulnerability Index
(1) Level of Isolation	(1) Prior History	(1) Degree of Trauma
(2) Geographical Isolation	(2) Level of Aggression	(2) Verbal Ability to Report
(3) History of Violence	(3) Level of Sophistication	(3) Victim's Level of Assertiveness
(4) Families' Method of Dealing with Anger	(4) Level of Coercion	(4) Victim's Awareness of Appropriate Sexual Behavior
(5) Attitudes Toward Sex	(5) Level of Empathy for Victim	(5) Victim's Level of Intellectual Functioning
(6) Limits Regarding Privacy	(6) Escalation	(6) History of Physical or Sexual Abuse
(7) History of Abuse	(7) Resistance	
(8) Access to Victim	(8) Denial	
(9) Current Stressors	(9) History of Psychiatric Disturbance	
(10) Confused Parent Roles	(10) History of Chronic Substance Abuse	
(11) Absence of One Parent	(11) History of Physical/Sexual Abuse	
(12) Parents' Attitude to Offense	(12) Social Skills	
	(13) Knowledge About Sex	
	(14) Level of Intellectual Functioning	

While there are differences in characteristics between SAY under and over the age of twelve, the most striking feature of this study is the magnitude of the offending behavior of these children. There are a significant number of incidents and victims identified in public agency case records. These children continue to exhibit sexually aggressive behaviors after identification and entry into the child welfare system. Although younger SAY were assessed by caseworkers as less likely to recommit sexually aggressive behaviors, they actually reoffend as often as older youth.

While the assumption is that females are the primary target of sexual aggression, this study indicates that, at least with child perpetrators, males are as frequently victims as females. This study also indicated that these behaviors are not one time incidents and cannot be characterized as playful sexual experimentation between children. To qualify for this study, the behaviors had to be coercive and non-consensual.

Not only are these youths perpetrators, they are also victims. Their significant behavioral dysfunction indicates children with profound disturbances who need to be held accountable for their behaviors, as well as assisted with resolutions of their behaviors. The first response of public agencies is to provide services to children and families in their own homes. These youth, however, tend eventually to be placed in out-of-home care either for their own protection or for the protection of others. It does not appear that the current service system has the appropriate placements necessary to meet the needs of these children and the other children with whom they are placed. It is also unclear whether the traditional resources and service response available are appropriate for these youth. Certainly, more research on the kinds of interventions most appropriate for these youths is needed.

Table 2
SAY Risk Factors with Significant Differences by Age

FAMILY & ENVIRONMENTAL CHARACTERISTICS	< 12 *p* values	> 12 *p* values
Level of Isolation	.03	
History of Violence	.00	
Family's Method of Dealing with Anger	.05	
Limits Regarding Privacy	.00	
History of Abuse	.01	
Parent's Attitude to Offense	.02	
SEXUALLY AGGRESSIVE YOUTH CHARACTERISTICS	**< 12 *p* values**	**> 12 *p* values**
Prior History		.01
Level of Aggression		.09 *
Level of Sophistication		.00
Level of Coercion		.00
Level of Empathy		.03
Escalation		.00
Resistance		.02
History of Chronic Substance Abuse		.00
History of Physical/Sexual Abuse	.01	
Knowledge of Sex		.01
VICTIM VULNERABILITY	**< 12 *p* values**	**> 12 *p* values**
Degree of Trauma		.05
Verbal Ability to Report	.08	
Victim's Awareness of Appropriate Sexual Behavior		.02
OVERALL RATING OF RISK TO REOFFEND**		.002

* Approaches significance.

** Younger youths were assessed as moderately likely to reoffend (84%) although data indicate 88% did reoffend while in placement. Twice as many older youths were predicted to reoffend, but reoffense reports were not significantly different.

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Youth in California State Psychiatric Hospitals

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As part of a program of research in children's mental health services, an analysis was conducted of children and adolescents placed in California State Psychiatric Hospitals during the 1990 to 1992 calendar years. Preliminary results suggest that the typical youth resident was a 14 year old Anglo American male with a psychiatric diagnosis of disruptive behavior disorder. With respect to social factors which may influence county utilization rates, our analyses indicate that population density was positively correlated with number of admissions while total population, youth population, per capita personal income, infant mortality, and juvenile arrest rate were unrelated. It is anticipated that system of care variables rather than demographic or clinical characteristics directly and powerfully affect the rate at which counties utilize state psychiatric hospitals, the most restrictive form of mental health care available to treat California youth who are severely emotionally disturbed.

Youth In California State Psychiatric Hospitals

The principal challenge in caring for youth who have serious emotional disturbances is organizing, integrating, and financing care to meet their multiple needs. Typically such children are served by several independent government agencies, such as the Department of Social Services (or Children's Services), the Department of Mental Health, the Department of Education, and the Department of Probation (or Juvenile Justice). These agencies work autonomously to maximize their own narrow focus, leading to interagency rivalry, conflict, and confusion for the consumer (Barber, Rosenblatt, Harris, & Attkisson, 1992). This loosely-linked strategy ultimately results in high expenditures, system inefficiency, and poor outcomes for children, youth, and families.

After observing such inefficiency and mismanagement in the mental health care system for youth, mental health service administrators and providers in Ventura County, CA, developed an innovative, comprehensive model of care designed to provide the greatest benefit to children with emotional disturbances at the lowest cost to the public sector (Jordan & Hernandez, 1990). The publicly funded Ventura Model emphasized interagency collaboration to achieve maximum efficiency. This model proved to be so successful that attempts were made to replicate the model in other counties in California. Three counties which were demographically and geographically distinct received state funds to test the efficacy of the Ventura model (Rosenblatt & Attkisson, 1992).

As part of an overall programmatic research effort directed at examining and understanding the various systems of care which serve the mental health needs of children and adolescents in California (Attkisson, Dresser, & Rosenblatt, 1991; Attkisson, Dresser, & Rosenblatt, 1993), an examination and evaluation of the impact of implementation of the Ventura Model in the three AB377 counties is currently being conducted (Rosenblatt & Attkisson, 1993; Rosenblatt, Attkisson, & Fernandez, 1992). The four evaluation project outcome variables include: (1) characteristics of the youth served, (2) group home expenditures and utilization, (3) special education residential expenditures, and (4) state hospital utilization. The current study concerns the fourth outcome variable - state hospital utilization - in the three experimental counties as well as counties throughout the state of California.

Method

An analysis of state psychiatric hospitalization of children and youth in the state of California was conducted. The results, which include the 693 children and adolescents hospitalized in California state psychiatric hospitals during the 30-month period between January 1990 and June 1992, are based on state information system records provided by the Department of Developmental Disabilities. The data pertain to the children and adolescents hospitalized in the two state psychiatric hospitals in California - Napa State Hospital, which serves predominantly northern California, and Camarillo State Hospital, which serves primarily southern California. These two hospitals represent the most restrictive form of care available in California for youth who are emotionally disturbed.

Our preliminary analyses have examined demographic and diagnostic characteristics of the hospitalized children, as well as cost data and potential regional influences on hospital utilization.

Results

Demographic Characteristics

With regard to demographic characteristics, the children hospitalized between January 1990 and June 1992 ranged in age from .16 to 18.93 years with a mean age of 14.50 years (SD = 2.75). Most of the children were male (72.4%) and were Anglo American (58.4%). Other ethnic groups represented in this sample of state hospital residents included African Americans (22.4%), Latino Americans (14.1%), Asian/Pacific Islanders (3.5%), and Native Americans (0.9%). These data suggest that, with respect to their representation in the general youth population, Anglo American children and adolescents are over represented in the state hospital population (58.4% of hospital sample as compared to 45.9% in the state of California) as are African Americans (22.4% as compared to 8.0%). In contrast, Latino American children and adolescents are underrepresented in the state hospital population (14.1%) as compared to their representation in the youth population of the state of California (35.3%).

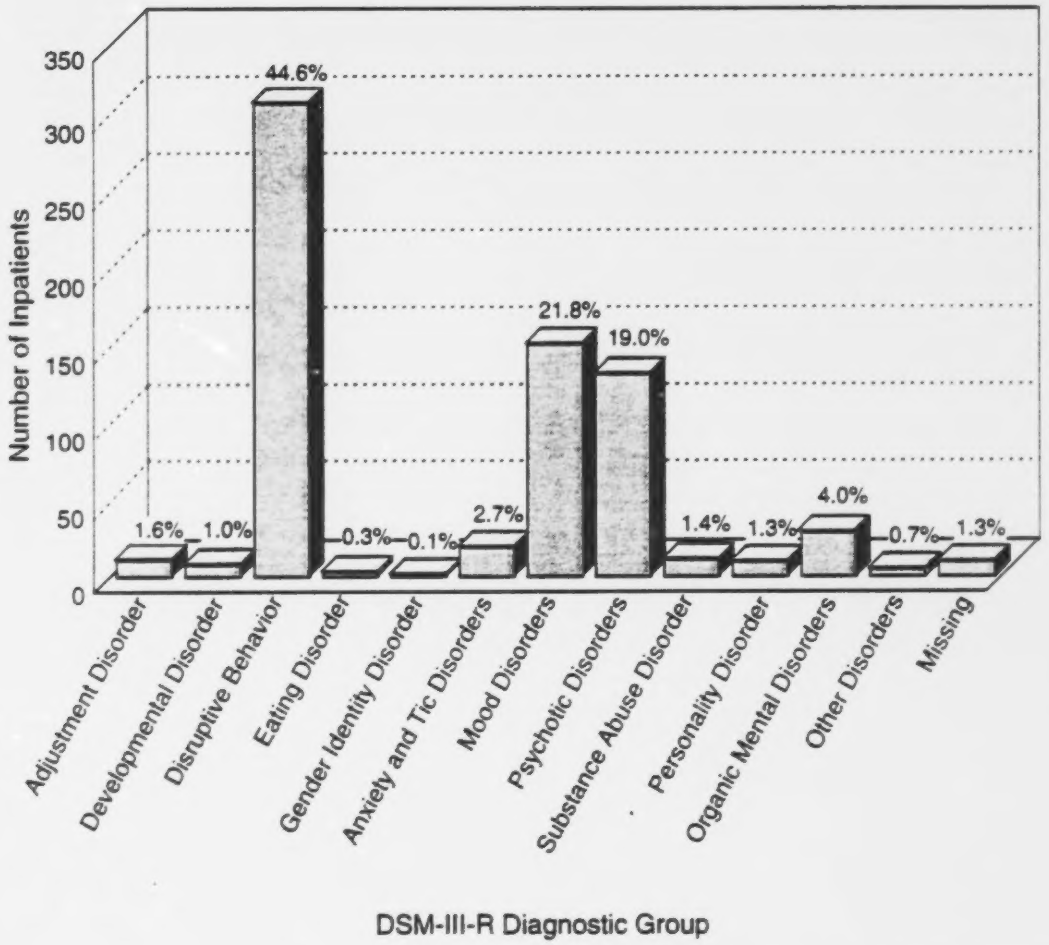
Diagnostic Characteristics

As can be seen in Figure 1, the most common DSMIIIR psychiatric diagnoses assigned to children hospitalized during the 30-month period of the current study were the disruptive behavior disorders (44.6%). Other prevalent diagnostic types mood disorders (21.8%) and psychotic disorders (19.0%). A relative minority of children were diagnosed with anxiety and tic disorders (2.7%) and organic mental disorders (4.0%).

Cost Characteristics

Bed cost per day for this sample of hospitalized children and adolescents ranged from $.80 to $621.42 with a mean per day bed cost of $220.26. Ancillary costs, which include all non-standard bed related charges, ranged from $0.0 to $359.32 per day with a mean of

Figure 1
DSM-III-R Diagnoses of Youth Placed in State Hospitals
January 1990 - June 1992
(*N* = 693)



$18.06 per day. Total per day costs, which equal the sum of bed costs and ancillary costs, ranged from $1.78 to $688.41 with a mean per day total cost of $238.32.

County Hospitalization Rates

In order to examine potential regional influences on state psychiatric hospitalization rates, the number of children hospitalized by each of the 58 California counties during the

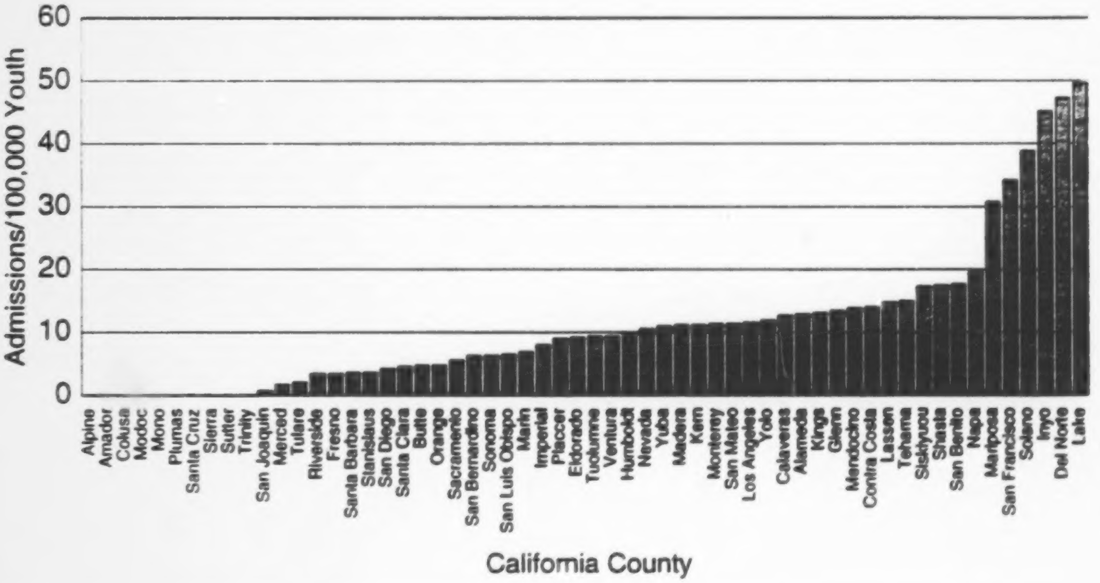
30 month period of January 1990 through June 1992 was determined. As can be seen in Figure 2, state psychiatric hospitalization admissions per 100,000 youth for this period ranged from zero, in several rural counties and in one AB377 suburban county, to 49.62 in Lake County, a rural county located in northern California. Of those counties who hospitalized children during the study period (*n* = 48), most (*n* = 26) utilized the state hospitals at a rate of 8 to 20 children per 100,000 youth. Given the large variability in hospitalization rates across counties, correlational analyses of the relationship between selected county characteristics and hospitalization rates were conducted.

County Population Characteristics

The 58 California counties are very diverse. Differences are especially observed with regard to geographic size, population and population distribution, density, ethnic composition, and social risk factors. Indeed, total county population, according to 1990 census data, ranged from 1,113 people in Alpine County, a small rural area in the Sierra Nevada mountain range, to 8,863,164 people in Los Angeles County, a large urban area in southern California. Similarly, county youth population ranged from 282 in Alpine County to 2,326,110 in Los Angeles county. Despite this variability, total population and total under age 18 population was unrelated to state psychiatric hospitalization rates.

Population density, or the number of persons per square mile, also varies greatly across the 58 California counties, ranging from two people per square mile in Alpine, Inyo, and Modoc counties (all rural areas along the California-Nevada border) to 15,502 people per square

Figure 2
State Hospital Youth Residents
January 1990 - June 1992
(N = 693)



mile in San Francisco County. Unlike the other county population characteristics examined, population density was positively correlated with state psychiatric hospital utilization ($r = .50$, $p < .001$), indicating that counties composed primarily of urban areas (such as San Francisco, Orange, and Los Angeles counties) utilize the state psychiatric hospitals for their mentally ill children and youth at a higher rate than do counties which do not contain urban areas.

Minority youth populations also vary widely across California counties, ranging from 8.9% in Nevada County, a rural area in the Sierra Nevada mountain range, to 81.1% in Imperial county, a rural area in southern California that borders Mexico. However, no relationship between a county's proportion of minority youth and its rate of state psychiatric hospitalization was observed.

Social Factors

Other potential regional influences on state psychiatric hospital utilization were also examined. These variables included social factors such as per capita personal income, infant mortality rate, and rate of juvenile arrests. As with most of the demographic characteristics, these factors also varied greatly across the state of California. For example, using 1989 county level data bases, mean per capita personal income in Yuba county, a rural county in central California, was $11,801 while Marin county, an affluent area north of the San Francisco bay, had a mean per capita personal income of $34,983. Similarly, infant mortality rates ranged from 0 deaths per 100,000 live births in 21 rural counties to 11.7 deaths per 100,000 live births in Shasta County. Finally, juvenile arrest rates were also highly variable, ranging from 496 reported arrests per 100,000 youth in Modoc County to 6498 per 100,000 youth in Shasta County.

Discussion and Conclusion

This report presents data on the ways in which various demographic, diagnostic, and social factors are related to state psychiatric hospitalization utilization by children and youth. Considering all 58 counties across the state of California, our analyses focused on the population of children ($N = 693$) hospitalized in the two state psychiatric hospitals for children and youth in California between January 1990 and June 1992. Although many demographic and diagnostic factors, as well as potential social factor influences, were examined, these variables were found to be largely *unrelated* to the rates at which counties made use of state psychiatric hospitals for their children and adolescents who were mentally ill. Given the current results, future research will examine potential system of care influences on state psychiatric hospitalization of children and youth. System of care attributes to be studied include availability of less restrictive alternative forms of care, the presence of a comprehensive system of care model for children's mental health services, level of service integration, methods of financing care, and the availability of other acute psychiatric care facilities within county jurisdictions. In order to better understand the most intensive and restrictive levels of the mental health service system for seriously emotionally disturbed youth, large-scale research efforts which examine system of care influences along with demographic, diagnostic, and social factor influences must be implemented.

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Admitting Problems: A Key Construct in Brief Adolescent Psychiatry Hospitalization

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Introduction

The inpatient treatment of children and adolescents has undergone enormous changes over the past 20 years (Jeremin & Philips, 1988). In contrast to the lengthy, exploratory treatments of years past, the typical aim of hospitalization nowadays is, to quote Harper, "to get the patient out of the hospital" (1989).

The evolution of brief psychiatric hospitalization for children and adolescents has been largely economically, not clinically, driven. The evolution was a rapid one, and we are just beginning to define both theory and practice (Harper, 1989; Nurcombe, 1989; Woolston, 1989; Livingston, Taylor & Crawford, 1990; Kazdin, 1989), to find a place for this intervention within the broader spectrum of mental health services (Jeremin & Philips, 1988), and to look at treatment outcome (Singer & Song, 1991; Kolko, 1992; Blotcky, Kimpero & Gossett, 1988; Pfeiffer, 1989). Much remains to be learned about what kinds of treatment work best for different kinds of patients.

One construct of importance to both clinicians and third-party payers is the notion of the Admitting Problem (AP). Admitting problems are not diagnoses, nor are they simply symptoms which are present at the time of admission. Rather, they are the specific difficulties which make it unacceptable for a patient to be in any setting less restrictive and intensive than a hospital.

AP's are the focus of third-party payers at the time of hospitalization. The status of the AP's remains a central concern after admission, as reviewers attempt to evaluate the need for continued inpatient treatment.

AP's have also come to play a central role for clinicians who value expeditious inpatient treatment. Identifying AP's is key to developing a treatment plan, to coordinating efforts within a multidisciplinary team, and to monitoring the effectiveness of treatment. The resolution of the AP's may not be a sufficient condition for successful inpatient treatment, but it is certainly a necessary one.

This study looks at how AP's relate to one another, to length of stay (LOS), and to diagnosis. Specifically, the study addresses three questions. First, in a given inpatient setting, can a set of AP's be defined in such a way that (a) the AP's are independently meaningful, and (b) all patients have one or more of the identified AP's? Second, how are AP's related to LOS? Third, to what extent can AP's and demographic data be used to anticipate discharge diagnoses?

Method

Setting

The Adolescent Psychiatric Treatment (APT) Unit is an acute 8-bed facility in a university general hospital. Most forms of severe psychopathology are represented. AU patients undergo multidisciplinary evaluation, including daily individual sessions; assessment in nursing activities, group therapy, school, and occupational therapy; family assessment; medical assessment; and the collection of historical data. Most patients also undergo psychological testing as well as speech and language screening.

The aim of hospitalization is to resolve the AP's and achieve a reasonable likelihood of continued clinical stability and appropriate use of outpatient resources. With these goals in mind, inpatient treatments typically include a structured milieu treatment program; individual, group, and family therapies; and, as indicated, psychotropic medication and individualized behavioral programs.

Data Collection

Data were collected on 94 patients admitted consecutively over a 13-month period. The author served as attending physician for all subjects.

Based on previous experience with the Unit's patient population, the Admitting Problems Inventory (API) was developed. The API defines seven common admitting problems: suicidality, self-injury, violence, psychotic symptoms, depression, somatic symptoms, and anxiety (See Table 1). The presence of any of these symptoms was not sufficient for it to be designated as an AP: it had to be severe enough to make hospitalization necessary. When a patient was admitted, the author identified and recorded zero to three AP's from the list of seven.

Axes I and II diagnoses (Diagnostic and Statistical Manual, Third Edition, Revised, 1987) were determined by the author based on the multidisciplinary evaluation and, along with

Table 1
Seven Admitting Problems Identified on the Admitting Problems Inventory (API)

1. Suicidality: suicidal ideation, intent, threat, or act
2. Violence: threat or act of property destruction or personal assault
3. Depression: severely depressed mood, withdrawal, or vegetative symptoms
4. Self-injury: any self-injury, regardless of intent
5. Psychotic Symptoms: hallucinations, delusions, or irrational thinking
6. Somatic Symptoms: physical and/or medical non-compliance
7. Anxiety: severe anxiety

demographic variables and LOS, were recorded at discharge. Axis I diagnoses were grouped into four categories. Two of these - disruptive behavior disorders and anxiety disorders - are identical to those categories found in DSM-III-R. The thought disorders category includes schizophrenia, schizophreniform disorder, schizoaffective disorder, and psychotic disorder, not otherwise specified (NOS). A fourth broad category, mood disorders, includes DSM-III-R mood disorders, adjustment disorders, and psychological factors affecting physical disorder.

Subjects

Of the 94 original subjects, two were excluded from the study. These two were excluded because one subject had none of the seven AP's in the study, and the other was removed from the hospital by his family before he could be accurately diagnosed.

The remaining 92 patients consisted of 46 boys and 46 girls. Mean age was 14 years, 7 months (*SD* 19 months), with a range of 11 years, 2 months to 17 years, 10 months. Sixty-three (68%) were White and 29 (32%) were from other ethnic groups. Eighty-two (89%) were on Medicaid and the rest had other insurance. Length of stay (LOS) ranged from 1 to 76 days, with a mean of 19.9 days (*SD* 13.7 days).

Results

Thirty-four subjects (37 %) had one AP, 40 (43 %) had two AP's, and 18 (20 %) had three AP's. As seen in Table 2, suicidality was the most common AP, followed by violence, depression, and self-injury. χ^2 analysis showed two significant two-way interactions among the seven AP's: suicidality correlated negatively with both violence ($p < .05$) and somatic symptoms ($p < .10$). Log-linear analysis revealed no significant higher order interactions.

The frequencies of Axis I diagnoses are given in Table 3. Subjects often met criteria for more than one diagnosis. No attempt was made in these cases to designate one diagnosis or another as "primary".

Table 2
Frequencies of Admitting Problems

Admitting Problems	Number of subjects
Suicidality	46 (50%)
Self-Injury	26 (28%)
Violence	33 (36%)
Depression	27 (29%)
Psychotic symptoms	17 (18%)
Somatic symptoms	14 (15%)
Anxiety	5 (5%)

Table 3
Diagnoses at Discharge

	Number of subjects
Mood Disturbance	65 (71%)
Adjustment Disorder [1]	26
Dysthymia	37
Major Depressive Disorder	16
Depressive Disorder NOS	4
Bipolar Disorder/ Bipolar Disorder NOS	3
Psychological Factors Affecting Physical Condition	7
Disruptive Behavior Disorder	24 (26%)
Attention Deficit Hyperactivity Disorder	5
Oppositional Defiant Disorder	9
Conduct Disorder	12
Thought Disorder	11 (12%)
Psychotic Disorder NOS	5
Schizophrenia	4
Schizoaffective Disorder	2
Schizophreniform Disorder	1
Anxiety Disorder	16 (17%)
Post-traumatic Stress Disorder	10
Anxiety Disorder NOS	4
Panic Disorder	2
Generalized Anxiety Disorder	1

[1] Includes adjustment disorder with depressed mood, with mixed disturbance of emotions and conduct, with mixed emotional features, and with withdrawal.

Length of stay (LOS) showed no correlation with diagnostic category, number of AP's, or demographic variables. LOS did correlate, however, with two types of AP's: violence (mean LOS 15.5 versus 21.9 days, $p < .03$), and anxiety (40.5 versus 19.0 days, $p < .01$).

Stepwise logistic regression was employed to construct a model which used data readily available at admission – gender, age, ethnicity, medical coverage, and AP's – to anticipate Axis I discharge diagnoses (See Table 4). The model correctly predicted diagnostic category 82 to 96% of the time. Sensitivity and specificity ranged from 0.67 to 0.99, with the exception of a low specificity in the prediction of anxiety disorders (0.33).

Discussion

The seven AP's in this study are not the only reasons that teenagers are hospitalized or, for that matter, the only reasons that they ought to be hospitalized. Nevertheless, the Admitting Problems Inventory (API) clearly fit the APT Unit population well. The AP's in this instrument proved not to be redundant. At the same time, out of the original 94 subjects, only one had none of the seven AP's.

On the APT Unit, AP's are used not only to guide the treatment plan, but the improvement of each AP is routinely rated at discharge. This data is used for Quality Improvement purposes and to study treatment outcome. Further work with the API has led to expanded definitions of the AP's (See Appendix).

At the time of admission, the patient, family, and third-party payers typically ask the clinician to estimate the length of stay. AP's appear to contribute to a more precise estimate than is otherwise possible. On the APT Unit, a patient admitted with an AP of violence is likely to have a relatively short hospital stay, while a patient admitted due to severe anxiety would be expected to stay much longer.

Violent patients may have a short LOS for two reasons. Some assaultive patients, once admitted to a highly structured, nurturing unit, quickly

Table 4
Stepwise Logistic Regression Model: Prediction of Diagnosis from AP's and Demographic Data

Diagnostic Category	Predictive AP's [a]	Other Predictive Variables [a]	Accuracy [b]	Sensitivity	Specificity
Mood Disorder	Anxiety (-4.71) Depression (3.85) Psychosis (-2.57) Suicidality (2.31) Somatic (1.56) [c]	Coverage (Medicaid 1.93) [c] Ethnicity (Non-white 1.52) [c]	84%	.79	.86
Behavior Disorder	Violence (2.65)	Gender (Male 1.63)	85%	.90	.67
Thought Disorder	Psychotic (2.94) Suicidality (-2.31)		92%	.95	.73
Anxiety Disorder	Anxiety (3.23)	Gender (Female 2.17) Coverage (Insurance 1.99) [c]	88%	.99	.33

[a] coefficient in parentheses

[b] percent of cases correctly classified as having or not having the diagnosis

[c] borderline significance (ratio of coefficient to standard error < 2)

abandon their violent behaviors. Treatment is focused on "shoring up their healthier coping mechanisms", and they may be discharged fairly quickly. Other patients continue to be threatening and even assaultive in the hospital. Because they antagonize staff and pose a physical danger to staff and peers, persistently violent patients are also at risk for being discharged after relatively short stays.

An AP of anxiety was associated with an unusually long average length of stay. These patients typically had histories of physical and sexual abuse and suffered from post-traumatic conditions. Their long hospital stays almost certainly reflected the difficulty of safely, quickly, and effectively reducing their anxiety.

AP's in this study, combined with demographic variables, correlated in the logistic regression model with diagnostic categories. Clearly, something would be amiss were this not the case, since both AP's and DSM-III-R diagnoses reflect symptomatology. The strength of the correlation suggests that, in a given setting, a logistic regression model could possibly be utilized at admission to anticipate likely diagnoses, thereby facilitating evaluation and treatment.

Beyond simply anticipating Axis I diagnoses, AP's may well carry clinically meaningful information beyond that conveyed by diagnosis. The possibility that AP's have prognostic value for the post-discharge course is currently under study.

This exploratory study would have been strengthened by the use of standard assessment measures and the identification of AP's and diagnoses by two independent clinicians. Further study of the construct of admitting problems is warranted. Research should be undertaken in a variety of inpatient settings, with particular attention be given to the relationship between AP's and treatment outcome. Findings will benefit patients who receive inpatient treatment, as well as those who pay for it.

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Appendix: Expanded Definitions of Admitting Problems for the Admitting Problems Inventory

Admitting Problems (AP's) are those difficulties which necessitate hospitalization, i.e., those presenting problems **which make outpatient evaluation and treatment untenable.** In deciding whether to call a given difficulty an AP, **take presenting symptoms at face value;** avoid reading meanings into symptoms and behaviors.

1. **SUICIDALITY: Suicidal Ideation, threat or attempt.**
   The thought of self-destruction – even if vague or fleeting – is a necessary condition for this AP. Self-injury without such ideation – e.g., self-mutilation strictly to ease psychic pain – would not be called suicidality. Admission for a "suicide gesture" merits this AP as long as the patient had any thought that life was not worth living.
2. **VIOLENCE: Ideation, threat, or non-accidental act of property destruction or physical assault.**
   The rationale for the violent behavior is irrelevant. For instance, a patient who is assaultive because he is psychotic merits AP's of both psychotic symptoms and violence. On the other hand, mere hostility or agitation do not, by themselves, merit an AP of violence.
3. **DEPRESSION: Severely depressed mood, withdrawal, or vegetative symptoms.**
   This is the most difficult AP to determine. The depressive symptoms must be so severe or pervasive that they stand on their own – independent of any associated suicidality, psychotic symptoms, self-injury, etc.– as a sound indication for *inpatient* evaluation/treatment. It is neither necessary nor sufficient for the symptoms to meet criteria for major depression: rather, they must make outpatient intervention unsuitable.
4. **SELF-INJURY: Any physical self-injury, regardless of intent.**
   Examples include injuries from breaking a window or from physical recklessness (as in ADHD): overdoses, wrist slashes, and other self-harm from suicide attempts: and self-mutilation. Any overdose – whether or not it caused any actual toxicity – should be considered self-injury. Self-injury does *not* include true accidents, substance abuse, or provoking others to violence.
5. **PSYCHOTIC SYMPTOMS: Hallucinations, delusions, or disorganized thinking.**
   Psychotic or psychotic-like symptoms at admission are usually – but not always – an AP. In addition to the symptoms listed above, the presence of perceptual distortions or persecutory ideations warrants this AP. Confusion, flashbacks without hallucinations, and dissociative symptoms such as time lapses do not, by themselves, merit an AP of Psychosis.
6. **SOMATIC SYMPTOMS: Physical symptoms and/or medical non-compliance.**
   These must be severe or pervasive enough to warrant inpatient psychiatric intervention. Example: a diabetic girl with repeated complications secondary to psychosocial factors.
7. **ANXIETY: Severe anxiety.**
   This must be severe or pervasive enough to stand on its own – independent of suicidality, psychotic symptoms, etc. – as an indication for hospitalization.

The Mental Health of Homeless Adolescents: Preliminary Findings

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Preliminary results of a mental health assessment of adolescents who are homeless, conducted within the context of an evaluation of the effectiveness of case management, are reported. The adolescent population being served evidenced generally high rates of axis 1 DSM-IIIR disorder, such as conduct disorder and major depression. Comparison of these findings with other studies of youth who are either seriously emotionally disturbed (SED) or considered "normal" suggests that they resemble the former population more than the latter.

Introduction

Homelessness among adolescents is an increasingly serious problem across the U.S. (Hevesi, 1988; Sullivan 1988; Solarz 1988). Any estimate of the number of homeless youth in this country, however, is problematic (Rothman & David, 1985). Estimates of the number of such youths aged 11 to 18 who remain "homeless" for an extended period of time have increased from about half-a-million in 1975 to a million and a half in 1988 (Rotherman-Borus, Koopman, & Ehrhardt 1991).

Despite their increasingly large numbers, homeless youth are considered the most understudied of the homeless population—which is, in general, understudied. Research that has been conducted with such adolescents clearly suggests reasons for concern about their mental health and social functioning. Homeless adolescents often come from conflict-laden, violent, and/or dysfunctional families. Many of their parents have alcohol problems (National Network of Runaway and Youth Services, Inc., 1985; New York State Council on Children and Families, 1984; Rothman & David, 1985; Robertson, 1989) and most have experienced physical abuse, neglect and/or sexual abuse within their families (U.S. Department of Health and Human Services, 1986). In addition, many of these adolescents already have lengthy histories of contact with public social service systems, including multiple placements in foster care and residential treatment programs (Greater Boston Emergency Network, 1985; New York State

Council on Children and Families, 1984; Rothman & David, 1985).

The work reported here is part of a research-demonstration project with three specific goals:

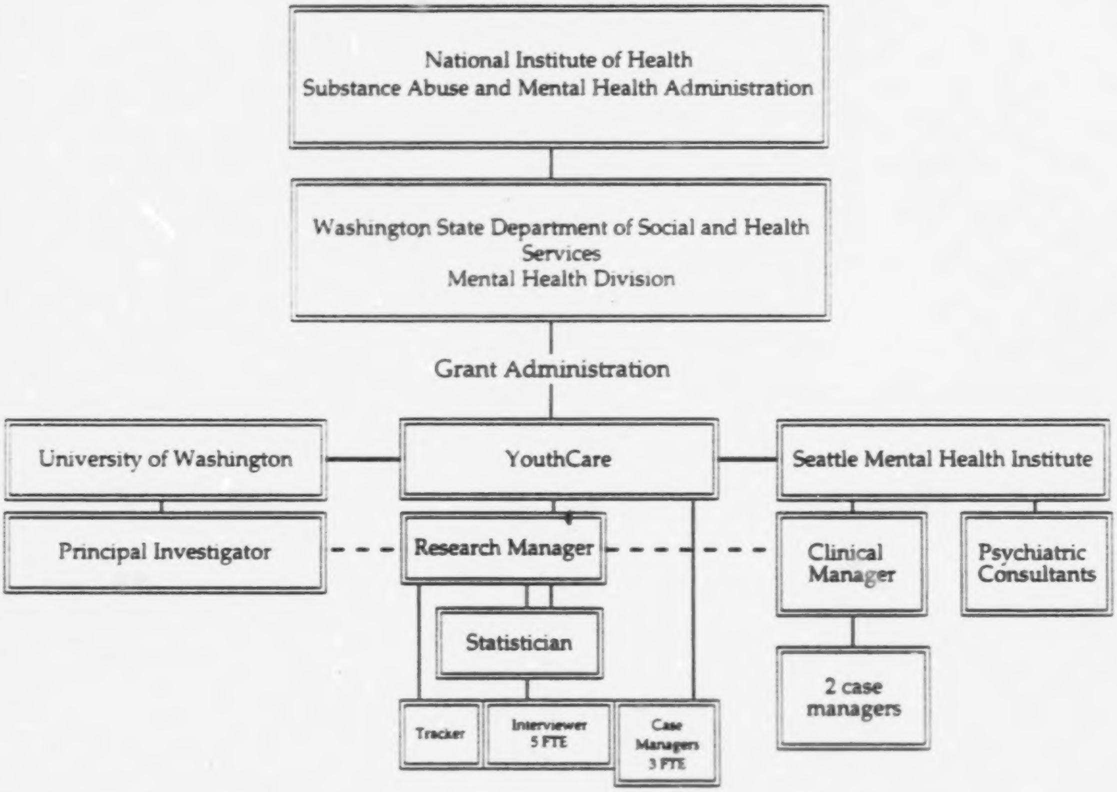
1. to characterize the population of homeless adolescents in terms of DSM-IIIR diagnostic criteria;
2. to implement an intensive case management program providing counseling and service brokerage; and
3. to evaluate the effectiveness of the intensive case management program, as compared to a regular case management program or no case management.

Implementation

The administrative organization of the project is outlined in Figure 1. The grant is an R-18 Research Demonstration grant under the CASSP program, now part of the Substance Abuse and Mental Health Services Administration (SAMHSA) under the National Institutes of Health (NIH). The grant was awarded to the Washington State Division of Mental Health, under the Department of Social and Health Services.

The Division of Mental health is responsible for coordination within the state Mental Health System. The Division contracts directly with

Figure 1
Administrative Organization of Project


National Institute of Health
Substance Abuse and Mental Health Administration
Washington State Department of Social and Health Services
Mental Health Division
Grant Administration
University of Washington
YouthCare
Seattle Mental Health Institute
Principal Investigator
Research Manager
Clinical Manager
Psychiatric Consultants
Statistician
2 case managers
Tracker
Interviewer 5 FTE
Case Managers 3 FTE

YouthCare, which administers the project and provides oversight and coordination with the collaborating agencies, Seattle Mental health Institute and the University of Washington. The Principal Investigator is faculty at the University of Washington; Seattle Mental Health Institute provides clinical oversight of the program.

The service site is one of YouthCare's programs, the Orion Multi-Service Center. This is a street based program for homeless youth. The Research Director and the remaining research staff are YouthCare employees. The case management team is supervised by a Seattle Mental Health employee and is a blended team between Seattle Mental Health and YouthCare.

Methods

The data are from a sequential sample of individuals requesting YouthpCare services between 7/23/91 and 9/15/92. Sixteen clients of YouthCare's emergency shelter were approached about participation in July and August of 1991; recruitment was then shifted to YouthCare's Orion Center. In total, 225 adolescents were approached and invited to consider taking part in the study. Fourteen declined to take part, nineteen agreed to take part but did not appear for interviews, and six were ineligible because they were outside of the age range of 13 through 20 (inclusive), not homeless, or apparently dangerous to staff or clients. The data reported here were obtained from the remaining 186. After providing consent, participants were scheduled for initial interviews. The first of these included a life-time biography and a detailed biography of the last three months. A self-report booklet including the Achenbach Youth Self Report (YSR) and various other instruments was administered. The second interview session consisted of an administration of selected modules from the Diagnostic Interview Schedule for Children, version 2.1C. Two hours were allocated for each session.

Preliminary Results

Participants ranged in age from 13 through 20 with a mean age of 16.8 years. Thirty-six percent were female and 64% were male. The sample was ethnically diverse: roughly half (52%) identified as white, 14% identified as African-American, 4% as Native American, 22% as mixed, 4% as Hispanic, and 4% as Asian, Pacific Islander, or Other.

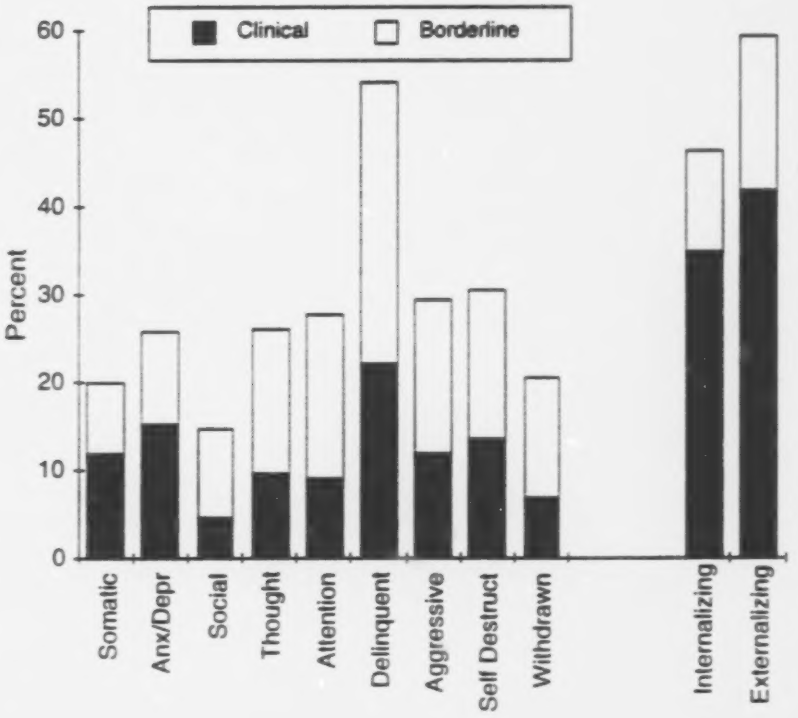
At the time of the first interview, the most common living arrangement was an emergency shelter (45%), followed by staying with friends without paying rent (14%) and living on the street or in an abandoned building (also 14%). In keeping with previous research, reported rates of lifetime abuse were high. Over half report that they have been physically abused (53%), and about a third (38%) report that they have been sexually abused.

Mental Health Data

As part of the routine interviews, all clients filled out the Achenbach Youth Self Report (YSR). The scoring is based on the expected results in a normative population. The 2% of the population with the worst scores are considered "severe" or "clinical" cases, and the next 3% are considered "moderate" or "borderline" cases. In a normative population, then, 5% of the cases would score as either borderline or clinically significant.

One hundred and seventy seven of the clients returned scorable YSRs. Results are reported in Figure 2. The proportion of participants whose reports indicated clinically significant or borderline clinically significant emotional or behavioral disturbance is consistently much higher than the expected 5% in all subcategories, as well as in the broad categories of internalizing and externalizing disorders.

Figure 2
Results of 177 Youth Self Reports Administered to Homeless Adolescents in Seattle, 1991 - 1992.



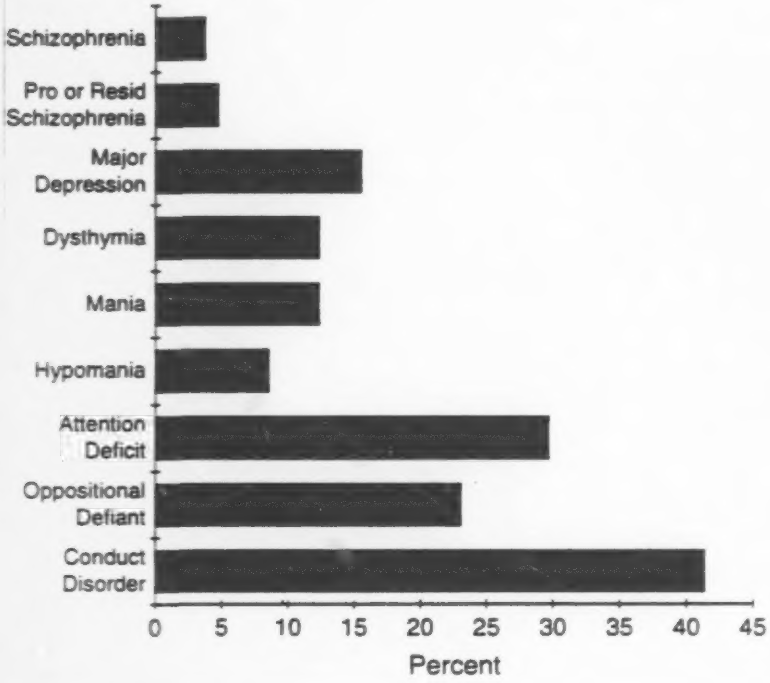
The Diagnostic Interview Schedule for Children (DISC), version 2.1C, was also administered. The DISC determines if a participant meets DSM-IIIR criteria on the basis of answers to a highly structured series of questions. The basic results for 186 DISCs are reported in Figure 3. As this figure indicates, 41% meet the criteria of conduct disorder and another 23% meet the criteria for oppositional defiant. Thirty percent meet the criteria for attention deficit/hyperactivity, which is very comparable to the figure obtained with the YSR. About 25% meet the criteria for mania or hypomania, and 28% meet the criteria for dysthymia or major depression. About 5% show symptoms of prodromal or residual schizophrenia, and about 4% meet the criteria for schizophrenia.

Discussion

In order to place these findings within a general context, these results can be compared with those of two other studies, one of a normal population and one of a group of adolescents who were studied because it was already known that they met criteria for a serious emotional disturbance. The two comparison studies also used structured interviews leading to computer generated diagnostic categories. Greenbaum, Prange, Friedman, and Silver (1991) administered an earlier version of the DISC, which generates diagnosis based on DSM-III, to 547 adolescents aged 12 to 18. All adolescents in their sample had been identified by either mental health or public school systems as having serious emotional disturbances in accordance with Public Law 94-142. The second study, by Kashani, Beck, Hoeper, Pallahi, Corcoran, McAllister, Rosenberg and Reid (1987), administered the Diagnostic Interview for Children and Adolescents (DICA) to a normative sample of 150 adolescents, aged 14 to 16. The prevalence rates we use in our comparison, illustrated in Figure 4, are based on the percent of adolescents who met *minimum* threshold levels for diagnosis.

As Figure 4 indicates, the rates of mental health disorders exhibited by the initial sample of homeless adolescents much more closely approximates those of the seriously emotionally

Figure 3
DSM II R Diagnosis, per DISC



disturbed sample than the normative sample. This very clearly underscores the urgent need to develop appropriate and effective services for this population of understudied youth.

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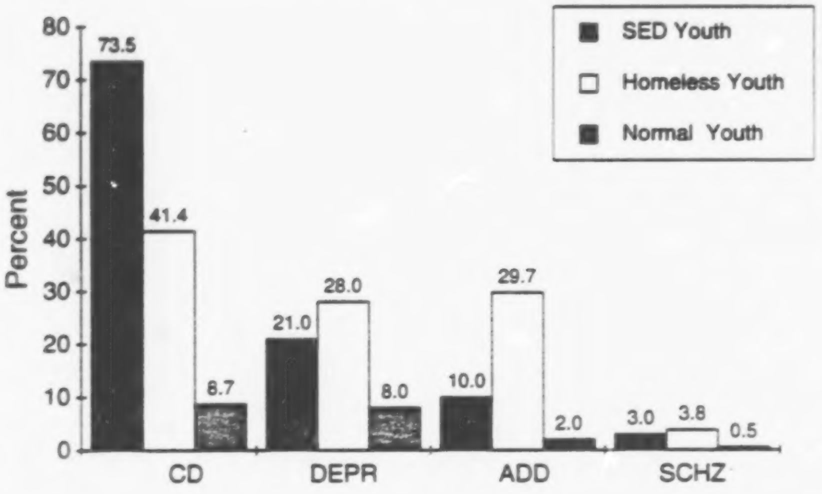
Figure 4
DSM-III Disorders in Three Adolescent Samples



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Utilization of Mental Health Services in a Tri-Ethnic Sample of Adolescents

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In our study of 2092 junior and high school students from two diverse regions in Texas (the lower Rio Grande Valley and Galveston County), we examined utilization of mental health and medical services as well as ethnicity and total problem score on the Youth Self Report form of the CBCL. We found that Hispanic youth used significantly less outpatient ($p < 0.001$) and inpatient ($p < 0.05$) services than white youth, while African-Americans did not differ significantly in outpatient utilization, but markedly so on inpatient days (no utilization by any African-American youth). There were similar differences in the utilization of medical care except for similar rates of inpatient utilization by white and African-American youth. The findings suggest that availability of child mental health services pay a major role in utilization by minority youth, but cultural factors may also play a significant role.

Introduction

There has been increasing interest in the last few years in the organization and utilization of mental health services for children and adolescents (Cross, Bazron & Isaacs, 1989). The development of these services have lagged behind those for adults, and many areas of the U.S. still suffer critical shortages. This is especially true for services for children and adolescents from ethnic and racial minorities (African-American, Hispanic, Asian-American and Native-American.) However, to this date there has been little research addressing the access and utilization of mental health services by these growing populations which in some areas of the country are the numeric majority. Many authors have suggested that there is marked underutilization of mental health services by minority children and their families. Such underutilization leads to the complication of morbidity associated with emotional or psychiatric disorders and the displacement of such youngsters either to the social services or legal system. In addition to the absolute shortage of mental health services for children, other barriers which may impede their utilization include financial constraints and the lack of cultural competence in such services.

In our study of junior and senior high school students we examined the utilization of mental health services, ethnicity and other associated factors. The regions surveyed differ significantly in demographic composition and services resources. The lower

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Study supported in part by R01-MH44214, Center for Cross Cultural Research, National Institute of Mental Health.

Rio Grande Valley is one of the poorest regions in the U.S., predominantly rural, with an over 90 percent Hispanic population, and very few mental health services. The region of Galveston County studied is a predominantly working class with a majority white population and significant Hispanic and African-American representation. It has more accessible mental health services for youth, including a nearby university medical center with inpatient and outpatient resources.

Methods

Subjects

Two samples were obtained for this study. One sample included 838 junior high school and high school students in grades 7 to 12 from a moderate-sized school district in an industrial area of southeast Texas. The sample had a tri-ethnic composition, including 488 non-Hispanic whites, 194 Hispanics (primarily of Mexican-American origin), and 102 African-Americans. The second sample, which included 1690 junior high school and senior high school students, was recruited from two predominantly rural school districts in the lower Rio Grande Valley region of Texas, next to the U.S.-Mexico border. Over 94 % of this sample were Hispanics, primarily of Mexican origin. The samples were selected through stratified classroom sampling of the English class rosters of each district, controlling for the proportion of students in special classes (learning disabled, English as a second language, etc.)

Instruments

The self administered instrument packet used in this study included: 1) The Youth Self-Report version of the Child Behavior Checklist, an instrument which includes both a social competence section as well as a 113 item problem behavior section. (Achenbach, 1987) The problem behavior section yields both a total behavior score as well as internalizing, externalizing, and multiple problem scales with different items for males and females. For purposes of this study, we will focus on the total problem score and 2) A Youth Questionnaire, developed by our research team and patterned after the Life History form of the Diagnostic Interview Schedule, which included items on sociodemographic variables and health and mental health service utilization. The instruments were translated into Spanish using a forward/back translation and panel adjudication procedure. They were presented bilingually to all of the Valley subjects and the Galveston Co. subjects in ESL classes, with the Spanish version on the left hand of the booklet and the English version on the right.

Procedure

After recruitment in classroom sessions, parental consent was obtained through a letter sent to the home and a postcard mechanism for response. (A second stage of this study involved the administration of structured diagnostic interviews and required active, written consent. We will not focus on this data in this presentation.) The self-administered instrument packet was completed in a 45 to 50 minute classroom period in the English classes selected. A research assistant distributed and collected the instrument booklets, monitored their completion, and offered assistance as needed. Instrument booklets were assigned code numbers, with names and addresses stored separately.

Analysis

For purposes of this presentation, we used the PROC FREQ and PROC FORMAT functions of the Statistical Analysis System (SAS) as well as performing significance analyses (*t* tests). We have compared the utilization of health and mental health services across ethnicity, different levels of YSR total problem score, and study sites of Galveston County and the primarily rural lower Rio Grande Valley. We also examined composite health and mental health utilization across these variables using a rating system combining both hospital and outpatient utilization: Over 14 hospital days = 5 points, 1-14 hospital days = 4 points, over 10 outpatient visits with no hospital days = 3 points, 1-10 outpatient visits without hospital days= 2 points, no visits or hospital days= 1 point.

Summary of Results

1) Hospital utilization and outpatient utilization was significantly different amongst the three different ethnic groups, with outpatient utilization lower in Hispanics and inpatient utilization lower both in Hispanics and African-Americans (See Tables 1 and 2).
2) Mean utilization using our rating system was significantly different between Whites and Hispanics, with utilization by African-Americans being in the middle and not significantly different from the other groups (See Table 3).
3) There are significant regional differences in outpatient utilization and mean utilization ratings. However, inpatient utilization was not significantly different between the two regions (See Table 1,2 and 3).
4) YSR Problem total score was significantly correlated to level of service utilization, which serves to externally validate these measures (See Table 1,2 and 3).
5) Maternal education was not significantly related to utilization except in outpatient utilization amongst Whites. This points to perhaps a stronger effect of SES on the utilization by Whites than by minorities (See Table 4).
6) Amongst Hispanics, English fluency was correlated to outpatient utilization and English literacy was correlated to both inpatient and outpatient utilization. This suggests that language can serve as a barrier to utilization by Hispanics.
7) Amongst Hispanics, Spanish fluency and literacy does not seem to be correlated to utilization except for minimal fluency being related with a higher mean utilization rate. This indicates a modest effect of acculturation, with extremes of acculturation being associated with lower utilization.

Table 1
Hospital Utilization

Variable	Percent Hospitalized			
	Psychiatric		Physical	
	N	PCT	*N*	PCT
N	2,102	1.47	2,098	7.58
YSR PROB TOT (a)				
Under 50	1,277	0.94	1,271	7.40
51-68	412	1.46	413	7.51
69-79	163	2.45	163	7.98
80+	250	3.60	251	8.37
ETHNICITY (b)				
White	515	2.14	517	9.86
Hispanic	1,419	1.34	1,416	6.57
Black	95	0.00	92	9.78
REGION (c)				
Galv. Co.	793	2.02	791	9.10
R.G. Valley	1,309	1.15	1,307	6.66

a) Psych. Hosp.: $X = 13.14$, $df = 3$, $p < 0.05$
(b) Psych. Hosp.: $X = 35.0$, $df = 2$, $p < 0.05$

Table 2
Outpatient Utilization

Variable	Percent Seen in Outpatient Visits			
	Psychiatric		Physical	
	N	PCT	*N*	PCT
N	2,080	13.17	2,092	71.51
YSR PROB TOT (a)				
Under 50	1,259	8.74	1,267	69.53
51-68	410	14.63	410	71.71
69-79	162	19.14	162	78.40
80+	249	29.32	253	76.68
ETHNICITY (b)				
White	514	17.12	509	79.57
Hispanic	1,402	11.20	1,417	68.53
Black	92	18.48	95	71.58
REGION (c)				
Galv. Co.	792	17.42	790	78.10
R.G.V.	1,288	10.56	1,302	67.51

a) Psych. Outpt.: $X = 101.56$, $df = 3$, $p < 0.001$
(b) Psych. Outpt.: $X = 22.9$, $df = 2$, $p < 0.001$
(c) Psych. Outpt.: $X = 20.15$, $df = 1$, $p < 0.001$

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Conclusions

1) Although regional differences in access to services impacts the level of mental health services utilization by different ethnic groups, cultural factors also appear to play a significant role. This is also reflected in the relationship between English fluency/literacy and utilization in Hispanics. These findings are somewhat in contrast to those of Zahner, et al, who found no differences in utilization by Hispanics and African-Americans (though the study was conducted in New Haven, which has both a large minority community and high levels of services.)

2) Of special concern is the very low rate of hospitalization in African-American adolescents. Our sample of African-Americans was small, but the findings were consistent with Cohen, et al (1990), who found a major racial bias in referral to juvenile facilities, which may be where African-American youth may be referred.

3) The correlation of utilization with YSR Problem Total scores indicates that the utilization reported was generally appropriate for level of behavioral/emotional problems. Previous findings of this study (Pumariega, Holzer, and Swanson, 1991) indicated that there were no differences in YSR Problem Total scores amongst the different ethnic groups, so we can infer that there is no difference in the level of need for services.

Table 3
Health and Mental Health Utilization

	Mean Utilization Score			
	Psychiatric		Physical	
Variable	*N*	SD	*N*	SD
N	1.19	0.57	1.94	0.83
YSR PROB.TOT. (a)				
Under 50	1.12	0.45	1.90	0.82
51-68	1.19	0.56	1.96	0.84
69-79	1.30	0.70	2.03	0.80
80+	1.46	0.86	2.03	0.84
ETHNICITY (b)				
White	1.27	0.72	2.08	0.85
Hispanic	1.15	0.51	1.88	0.80
Black	1.20	0.43	2.04	0.94
REGION (c)				
Galv. Co.	1.27	0.69	2.04	0.83
R.G.V.	1.14	0.47	1.88	0.82

(a) Psych Util.
Under 50 to 69-79: $t = 3.68$, $df = 1420$, $p < 0.001$
Under 50 to 80+: $t = 7.81$, $df = 1507$, $p < 0.0001$
(b) Ethnicity
White to Hispanic: $t = 4.05$, $df = 1915$, $p < 0.0001$
(c) Region: $t = 5.10$, $df = 2079$, $p < 0.0001$

Table 4
Maternal Education and Mental Health Utilization

Level Ed.	White	Hispanic	Black
	Percent Utilization		
OUTPATIENT (a)			
Grade School	0.00	8.63	33.33
Some HS	30.91	12.90	16.67
HS Graduate	14.56	14.83	21.43
Some College	16.44	16.30	18.75
INPATIENT (b)			
Grade School	8.33	0.32	0.00
Some HS	5.45	4.80	0.00
HS Graduate	1.27	1.26	0.00
Some College	1.82	2.75	0.00
	Mean Utilization Score		
Grade School	1.25	1.11	1.67
Some HS	1.47	1.24	1.17
HS Graduate	1.22	1.19	1.21
Some College	1.28	1.14	1.19

(a) Outpatient
White: $X = 30.97$, $df = 3$, $p < 0.001$
Black & Hispanic: *n.s.*
(b) Inpatient: *n.s.*

4) Socio-economic level did not affect utilization as much in Hispanics and African-Americans as in Whites and did not appear to be as major a factor as regional access and cultural factors.

5) Further studies are needed to examine what appears to be a serious deficit in the levels of mental health services for minority youth. Replication of these findings in different settings (inner city urban, suburban, other multicultural settings) would help examine the impact of cultural context on service utilization. This is consistent with the concept of cultural competence in services, and points to a major barrier to utilization. (Cross, Bazron, and Isaacs, 1989)

Table 5

English Fluency & Mental Health Utilization in Hispanics

Level Fluency	Speaking		Reading/Writing	
	N	Pct.	*N*	Pct.
OUTPATIENT (a)				
None or Little	2	8.62	2	3.45
Well	51	10.10	68	12.45
Very Well	98	12.13	87	11.20
INPATIENT (b)				
None or Little	0	0.00	0	0.00
Well	6	1.18	6	1.09
Very Well	13	1.60	13	1.66
	Mean Utilization Score (c)			
None or Little	1.09		1.03	
Well	1.14		1.16	
Very Well	1.17		1.16	

(a) Outpatient:
Speak: $X = 6.02$, $df = 2$, $p < 0.05$
Read/Write: $X = 40.2$, $df = 2$, $p < 0.001$
(b) Inpatient:
Speak: *n.s.*
Read/Write: $X = 6.42$, $df = 2$, $p < 0.05$
(c) Mean Util.: *n.s.*

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Table 6

Spanish Fluency & Mental Health Utilization in Hispanics

Level Fluency	Speaking		Reading/Writing	
	N	Pct.	*N*	Pct.
OUTPATIENT (a)				
None or Little	43	12.65	76	12.54
Well	69	10.78	45	9.05
Very Well	27	8.94	20	10.8
INPATIENT (b)				
None or Little	3	0.88	10	1.63
Well	12	1.85	5	0.99
Very Well	1	0.33	1	0.54
	Mean Utilization Score (c)			
None or Little	1.17		1.18	
Well	1.60		1.12	
Very Well	1.11		1.14	

(a) Outpatient: *n.s.*
(b) Inpatient: *n.s.*
(c) Mean Util. Speaking
None/Little to Well: $t = 12.19$, $df = 1138$, $p < 0.0001$

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Transition of Youth with Severe Emotional Disabilities: Preliminary Findings

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This paper presents preliminary findings of a longitudinal study of transition of high school students with severe emotional disabilities. This exploratory research is at its mid-period of collecting data from the sample of high school students in the Severely Behaviorally Handicapped (SBH) program and Transitional Adjustment Program (TAP) in all high schools in a mid-size county in Ohio. A comparison group of students without disabilities was also selected. Data are collected through personal interviews of the students and their parent/guardian. The subjects in the first year cohort are followed for three years, and the subjects in the second year for two years. The preliminary findings of the first year student data revealed some differences between the students with behavioral/emotional disabilities and the comparison group youth. This study is funded by the Ohio Department of Mental Health.

Introduction

A recent study of a community-based sample of children, age 4 to 16, estimated the prevalence of childhood psychiatric disorder as 18.1% (Kashani et al., 1987). Brandenburg, Friedman, & Silver (1987) note remarkable consistency in their estimates in their comparative study of prevalence of disturbed children in various countries. Other studies estimate prevalence of childhood emotional disturbance between 14% and 20% (Connell, Irvine, & Rodney, 1982; Verhulst, Berden, & Sanders-Woudstra, 1985; Vikan, A., 1985; Anderson, Williams, McGee, & Silva, 1987; Bird et al., 1988; Offord et al., 1987). Many investigators further determine that up to 2% of children may require services at any point in time (Behar, Holland & MacBeth, 1987; Friedman, 1987). A preliminary report of a four-year longitudinal study conducted by University of South Florida indicates that the most common diagnosis in their sample was conduct disorder manifested in the forms of aggressive behavior, poor impulse control and difficulties in interpersonal relationships. Over half of their children received a diagnosis of anxiety or depression.

There has been a gradual increase in the number of children identified as "seriously emotionally disturbed" under the Education for All Handicapped Children Act (U.S. Department of Education, 1987). However, as stated by Knitzer (1982), the

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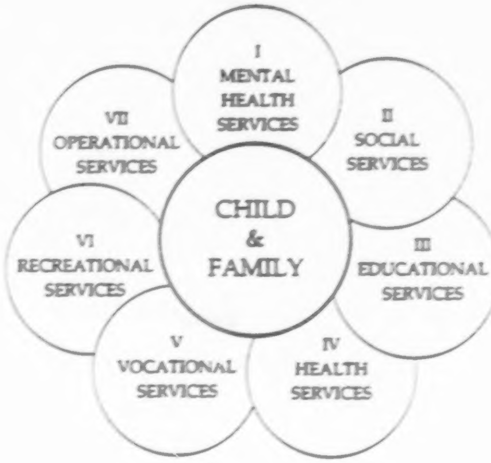
needs of children with severe emotional disturbances remain largely unaddressed. She estimates that two thirds of this group are not getting the services they need, noting the lack of an organized planning process for children in most states. Stroul and Friedman (1986) noted a lack of attempts to get mental health, child welfare, juvenile justice and education agencies to work together on behalf of children and youth with emotional disturbances.

While the transition to adulthood poses difficulties for all youths (Rosenbaum, Kariya, Settersten, & Maier, 1990), those with disabilities appear to fare less well than their nondisabled peers. A national study of youths with disabilities found that those with emotional disturbances were among the least likely to make a successful school-to-work transition (Wagner, 1989; Vander, 1990). Recently more attention has been paid to state-level policies and programs for youths with disabilities (Modrcin & Rutland, 1989; Koroloff, 1990). However, very little is known about the youths who are currently served, what combinations of services they are receiving, and what results are produced.

This research attempts to fill some of these gaps in our current knowledge, by describing needs and use of services among the youths with emotional disabilities before, during, and after the transition from adolescent to adulthood. Objectives of the study include the following: (1) to examine characteristics of the students who are placed in special classes due to their behavioral and emotional problems; (2) to examine the extent of mental health service utilization by those students and their involvement in other systems such as social welfare and criminal justice in the period transition from childhood to adulthood; (3) to examine perspectives of the parents of those children concerning their preparedness for independent living; and (4) to examine the extent of coordination and collaboration by the systems in helping those children in transition to adulthood.

A conceptual model used in this study was the system of care framework introduced by Stroul and Friedman (1986). The model is shown below. This study focused on the systems of mental health, social services and educational service.

Figure 1
Conceptual Model



SYSTEM OF CARE FRAMEWORK

SOURCE: Stroul, B. A. & Friedman, R. M.
A System of Care for Severely Emotionally Disabled Children & Youth (1986)

Method

This study used a longitudinal exploratory research design with the sample of high school students in the Severely Behaviorally Handicapped (SBH) program and Transitional Adjustment Program (TAP) in all high schools in a county. A comparison group of students without disabilities have been selected. Data are collected through personal interviews of the students and their parent/guardian. The subjects in the first year's cohort will be followed for three years, and the subjects in the second year for two years. A total of 40 students will be included in each of the disabled and comparison groups. It is hoped that the study will reveal how those students with emotional problems transition into adulthood, how they enter community mental health or other systems such as social welfare and criminal justice systems, and what are unmet needs of those children. The student questionnaire was based on the one used in the Florida study. The parent questionnaire was developed by the author. The instruments have been tested with the volunteers in the Cleveland area.

Findings

Characteristics of the Sample

Age. The age of the subject group ranged from 13 to 18 years with a mean of 15.57 years, while the comparison group's age ranged from 14 to 18 years with a mean of 15.54 years. Thus, both groups were almost identical in their age.

Gender. There were 20 male students (67%) and 10 female students (33%) among the SBH group. The comparison group consisted of 13 male students (33%) and 26 female students (67%). Thus, gender composition of these two groups was completely reversed.

Race. Among the SBH group, 22 were Caucasian (73%), 7 were African-American (23%), and one student's race was unknown. Thirty eight students (97%) of the comparison group were Caucasian and one student (<3%) was African-American. Thus, both groups were predominantly Caucasian.

Living Situation. Most of the students in both groups lived in their own home. However, more students in the SBH students lived in an apartment. Their living situation is shown in Figure 2. Almost half of the SBH group students (n = 14 or 47%) lived with mother only, while the majority of the comparison group students lived with both parents. The compositions of families are shown in Figure 3.

Figure 2

Living Situation of the Students

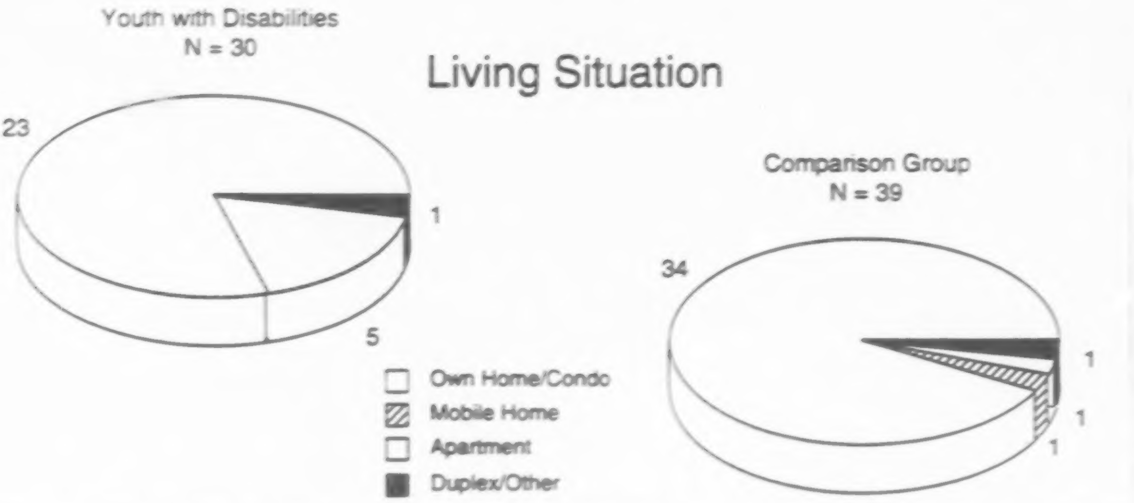
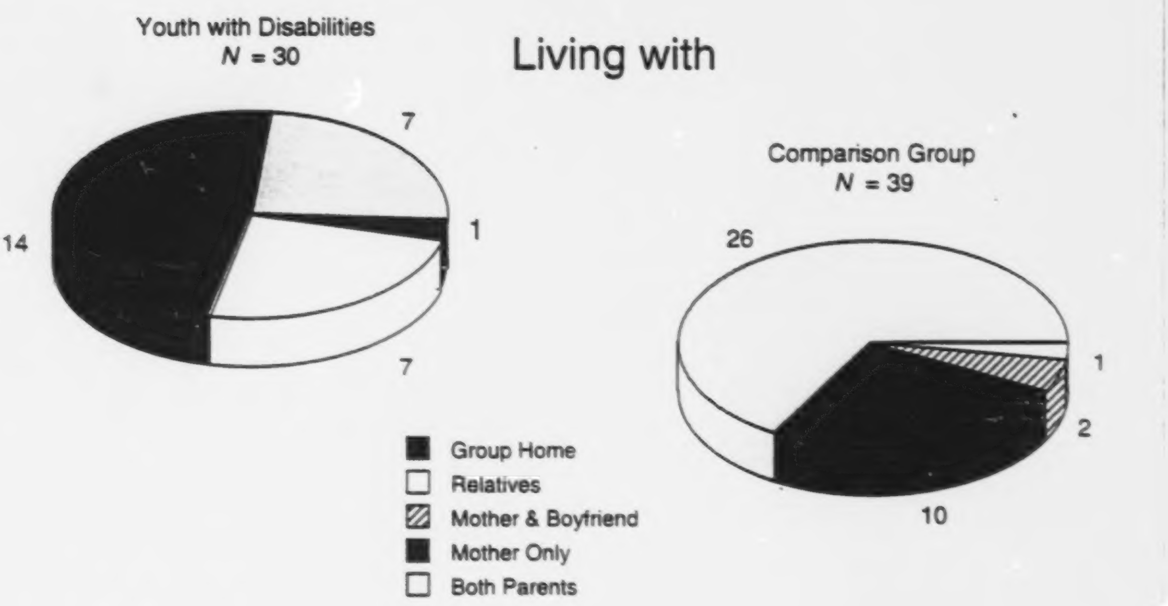


Figure 3
Family Composition



School

Students in both groups reported similar perceptions concerning what school was doing for them. Their responses are shown in Table 1.

Both groups of students reported that school taught them many skills such as reading newspapers and how to get along with others. However, they did not think that school taught them how to choose an appropriate job, how to perform the job, or how to keep it. Few students in either group felt that they did not learn parenting skills at school.

Independent Living Skills

Students' independent living skills were examined by what they reported that they had and what they could do for themselves. Results on selected aspects of independent living skills are shown in Table 2.

As shown in Table 2, students in the comparison group were more self-sufficient and confident about their own independent skills than students in the SBH group in several areas. Both groups were similar in other areas not listed in Table 2.

Social Aspects of Life

There were significant differences between the SBH group and the comparison group in several aspects of socialization process. Those aspects are shown in Table 3.

The students in the SBH group reported lower identification with their family members and named someone outside their family as their hero or role model, as compared to the comparison group counterparts. In addition, the SBH group reported significantly lower frequency in participating in physical activities. For example, only four SBH students reported that they participated in physical activities 4 - 5 times a week, while 17 of the comparison group (66%) reported the same.

Differences were noted in more private aspects of their social lives between the groups. Those differences are shown in Table 4.

As shown in Table 4, the SBH group students tended to become sexually active earlier than the comparison group students. The larger proportion of males in the SBH group may have influenced this finding. Most students in both groups reported having used alcohol while the use of other drugs was more common among the comparison group. Addiction to alcohol or other drugs was not suspected among the comparison group students, but was suspected in seven students in the SBH group.

Table 1
Students' Perception of What School Did for Them

Aspects of School Activities	**SBH Group ($N = 30$)**	**Comparison Group ($N = 39$)**
Perceived student participation	23 (77%)	32 (82%)
Staff helpful	28 (93%)	32 (82%)
Staff liked you	27 (90%)	36 (92%)
Things They Learned at School		
Getting along with others	24 (72%)	30 (77%)
How to communicate with others	28 (93%)	34 (87%)
Knowing right from wrong	29 (97%)	35 (90%)
How to read newspaper	26 (87%)	35 (90%)
Citizenship	16 (53%)	32 (82%)
Leisure activities	16 (53%)	22 (56%)
Budgeting	17 (57%)	11 (28%)
How to find job	16 (53%)	21 (54%)
How to cook or repair	15 (50%)	23 (59%)
Things They Did Not Learn at School		
How to choose job	4 (13%)	3 (8%)
How to keep job	5 (17%)	3 (8%)
How to perform job	1 (3%)	2 (5%)
Parenting skills	7 (23%)	5 (13%)

Table 2
Independent Living Skills

Independent Living Skills	**SBH Group ($N = 39$)**	**Comparison Group ($N = 30$)**
I Have . . .		
Saving account**	16 (53%)	26 (67%)
Checking account	3 (10%)	1 (8%)
Driver's license**	3 (10%)	13 (88%)
Job**	5 (17%)	15 (38%)
I Can . . .		
Cook**	19 (63%)	36 (96%)
Laundry**	14 (47%)	29 (74%)
Go shopping**	17 (57%)	33 (85%)

** χ^2 $p < .05$

Services Received:

Students were asked whether they had received various services. Their report is summarized in Table 5.

It is understandable that the SBH group students had received significantly more extensive counseling services than the comparison group students. Only 87% of the SBH group students reported receipt of health care while all comparison group students reported of having received health care. There were no significant differences in services received in other areas between the groups.

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Table 3
Some Aspects of Socialization Process

Aspects of Socialization	SBH Group ($N = 30$)	Comparison Group ($N = 39$)
Named someone close as "Hero"**	2 (6%)	11 (28%)
Wanted to be like family members**	7 (23%)	19 (49%)
Wanted to be like friends	4 (13%)	5 (13%)
Can discuss sex with family**	19 (63%)	33 (85%)

** χ^2 $p < .05$

Table 4
Private Aspects of Social Life

Aspects of Private Lives	SBH Group ($N = 30$)	Comparison Group ($N = 39$)
Have had sex (Age of the first intercourse)	23 (77%) 6 - 16 years old	15 (38%) 13 - 17 years old
Have been pregnant (females)	1	0
Have made girls pregnant (male)	4	0
Have had alcohol	26 (87%)	31 (79%)
Have used drugs	12 (40%)	31 (79%)

Thus, it was concluded that, except counseling services paid through the arrangement with the mental health system, students in both groups received similar types of services.

Discussion

Preliminary findings of the first year data of this longitudinal study revealed differences between the students with emotional disabilities and their counterparts without disabilities. The most evident findings included that the students with disabilities tended to come from female single parent households, have fewer independent living skills, enter sexual involvement at an earlier age, and had more trouble in controlling alcohol and drug intake. Furthermore, the students with emotional disabilities tended to name someone other than their family members as their heroes or role models unlike their nondisabled counterparts. This suggests that the students with disabilities had lower bonding with their parents. Effects of individual, group and family counseling are not known from the available data. However, the findings indicate that this group of youth needs skills for independent living, including personal care and prevocational skills. More comprehensive data analysis at the completion of the study will identify definite unmet needs among youth and their families in their transition to adulthood.

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Table 5
Services Received

Services	SBH Group ($N = 30$)	Comparison Group ($N = 39$)
Individual Counseling**	29 (97%)	13 (33%)
Family counseling**	18 (60%)	11 (28%)
Group counseling**	15 (50%)	6 (15%)
Alcohol counseling	5 (17%)	1 (3%)
Drug counseling**	5 (17%)	1 (3%)
Problem solving skills**	26 (87%)	23 (59%)
Health care**	26 (87%)	39 (100%)
** $\chi^2 p < .05$		
Getting along with others	21 (70%)	19 (49%)
Advice from religious figures	17 (57%)	17 (44%)
Continuing schooling	17 (57%)	16 (41%)
Transportation	15 (50%)	17 (44%)
Getting a job	14 (47%)	11 (28%)
Planning for future	12 (40%)	22 (56%)
Medication monitoring	8 (27%)	6 (15%)

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Follow-Up of Adolescents with Severe Psychiatric Impairment into Young Adulthood

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The McGraw Center Follow-Up Study was designed to document the psychosocial course of a cohort of youth discharged from psychiatric residential treatment. This study used a longitudinal, repeated measures design with interviews at 6 months, 1, 2, 3, 4 and 5 years post-discharge. Interviews included measurements of life course, quality of life and psychopathology. This paper presents life course outcomes, including residential arrangement, employment and educational status, financial support and psychiatric treatment of transition-aged youth, ages 18-22 years, at 1, 2, and 3-years post-discharge. The relationship between diagnosis and outcome measures is highlighted. The organization of data for this paper maximize comparability of the McGraw Center Follow-Up Study and the Transition Study within the National Adolescent and Child Treatment Study.

Introduction

Little is known about the long-term course of adolescents who are severely psychiatrically disturbed in terms of their social, academic, vocational, and psychiatric needs and/or functioning over time. The relationship between the child or adolescent who are severely disturbed and the "young adult chronic patient" has not been clearly established. Studies of adolescents discharged from inpatient psychiatric treatment have found several variables to relate consistently to outcome, including severity of psychopathology, type of onset of symptoms, intelligence, level of family dysfunction, type of treatment program, treatment completion and continuation of psychotherapy after discharge (Pfeiffer and Strzelecki, 1990; Blotcky, Dimperio & Gossett, 1984). These studies are limited due to a variety of methodological problems (Pfeiffer, 1991; Zimmerman and Sanders, 1988; Whittaker, Overstreet, Grasso, Tripodi, & Boylan, 1988). Most previous studies have been marked by the following limitations: 1) use of retrospective designs with subjects followed over widely varying periods of time; 2) a focus on youth whose type of impairment includes primarily behavioral or less serious affective disorders; 3) samples drawn from private psychiatric hospitals where patients tend to come from middle-to-high income strata; 4) inclusion of subjects from a wide age and developmental range; 5) low follow-up rates; and 6) failure to use uniform psychometric measurement from admission through follow-up.

The McGraw Center Follow-up Study was launched in 1981 with the opening of Washington's first Residential Treatment Facility for severely psychiatrically impaired youth. The study utilized a longitudinal, repeated measures design to document the life course, quality of life, psychopathology and consumer satisfaction of a cohort of 86 adolescents. The study was designed to identify subject and treatment factors which are predictive of later outcome, as reflected in school completion, employment, hospitalization, residential stability and financial independence.

Prior analyses of data from the McGraw Center Follow-up Study (Vander Stoep, 1991) have shown that the 19th year of life is a time of high risk for psychiatrically impaired youth, as reflected by rates of hospitalization and arrest, lack of gainful activities, and residential instability.

We have also found that youth with affective disorders have different life course patterns than do youth with thought disorders. Youth with affective disorders experience successful attempts at employment and education, interrupted by intermittent acute hospitalizations. Youth with thought disorders tend to sustain long-term, intensive involvement in the mental health system with little success at independent functioning.

Several factors have been identified which predict outcomes of school completion, employment status, post-discharge hospitalization, and risk for pregnancy. Diagnosis is the major factor which contributes to the ability to predict each of the outcomes. Additionally, the first three of these outcomes are all related to the extent of the gains which the youth makes during the residential treatment stay.

Description of the Study Group

The subjects in the study were 82 consecutive discharges from the McGraw Center Residential Treatment Facility between 1981 and 1987. Eighty-nine percent of these youth had had at least one psychiatric hospitalization prior to their admission to the Residential Treatment Facility. Almost half (42.7%) were in the custody of the state of Washington at the time of admission. Their length of stay ranged from 19-1316 days, with a median of 304 days. Participants were interviewed annually for five years post-treatment. For this paper, we examined outcomes for the subjects in our study who were transition age (18-22 years) at their three year follow-up interview. Five of the subjects were lost to follow-up or refused to participate in the three-year interview, yielding a follow-up rate of 94%.

The transition age sample consisted of 82 subjects, 44 males and 38 females. Their median age at admission to the McGraw Center Residential Treatment Facility was 16.1 years, with a range of 13-18 years. Twenty-three percent of the subjects were from ethnic minority groups. DSMIII-R diagnoses were assigned at intake by the staff adolescent psychiatrist and reviewed at each 90-day treatment plan review. A final diagnosis was assigned at the time of discharge. This discharge DSMIII-R Diagnosis was used in describing the subjects and in data analyses. Seventy-two of the subjects had a discharge diagnosis in one or more of three categories: thought, affect and conduct disorders. Of the total subject group (N=82), nearly half (46.3%) had an affective disorder diagnosis, including major depression, bipolar disorder, and dysthymia. Nearly one third (30.5%) had a thought disorder diagnosis, including schizophrenia, atypical psychosis and paranoid disorder, and just over a quarter (26.8%) had a conduct disorder diagnosis. Eleven percent of the 72 subjects with an affective, thought or conduct disorder had both an affect and conduct disorder diagnosis, 5.6% had both a thought and a conduct disorder diagnosis, and one subject had both a thought and an affect disorder diagnosis. Nearly half of the subjects had a personality disorder diagnosis on Axis II, and nearly half of the subjects had a history of drug and/or alcohol usage.

Results

Study results depict the life course of the transition age sample at three year post-discharge follow-up. Life course measures included high school or GED completion, employment status, residential status, financial sources of support, and participation in mental health treatment. Outcomes at one, two and three years post-discharge are compared. Differences in employment status, educational attainment, residential status, and psychiatric hospitalizations for three diagnostic groups, youth with affective, thought, and conduct disorder are examined. The outcome measures are comparable to those used for the Transition Study within the National Adolescent and Children's Treatment Study (Silver, 1993).

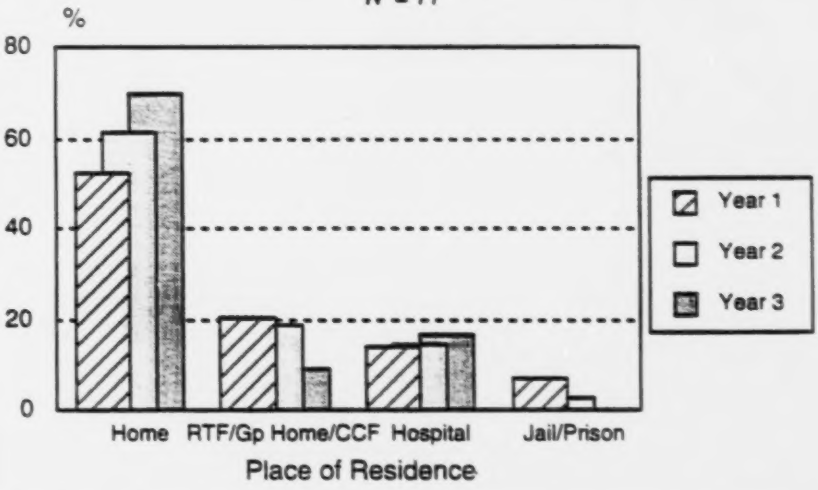
Living Arrangements. Figure 1 shows the proportion of the study group in a home, hospital, residential facility, and jail or prison at each post discharge anniversary. The proportion of youth who were in the hospital remained steady (14-17%) over the three year period. The proportion who were residing in a residential facility (RTF, CCF or group home) declined from 21% at the one year follow-up to nine percent at the three year follow-up, while the proportion living in a home in the community increased from 53% at one year follow-up to 70% at three year follow-up. The proportion of youth who were in jail or prison declined from 7% at one year follow-up, to none at the three year follow-up.

Examining the types of co-inhabitants of those who were residing in a home, the proportion of the study group who lived with their parents or foster families declined over time from 59% at year one to 44% at year three, while the proportion living with a partner and/or children increased (from 20% at one year follow up to 24% at three year), as did the proportion of subjects who reported living alone (from 9% at one year to 22% at three year) (See Figure 2).

Figure 1

Living Arrangements at 1, 2 & 3 year Follow Up

N = 77



An analysis of variance *($F = 15.30$, $df = 76$, $p < .001$)* indicated that whether or not a subject was living in a home at the three year follow-up differed significantly by discharge diagnostic group. Subjects with an affective disorder were most likely to be living at home (97% of subjects), compared to those with a conduct disorder (74%), and of subjects with a thought disorder diagnosis only (36%) were living at home. An analysis of variance *($F = 10.87$, $df = 76$, $p < .001$)* also indicated significant differences between the three diagnostic groups in whether or not subjects were residing in a hospital at three year follow-up. Subjects with a thought disorder diagnosis were far more likely to be residing in a hospital (46%) than were those with an affective disorder (0%) or a conduct disorder (5%).

Financial Support. The subjects who were receiving income from jobs remained steady over the three year period for both the major source of income (15% at one year to 17% at three year) or as any source of income (36% at one year to 38% at three year, See Figure 3). There was a decrease from the one to three year follow-up in the proportion of subjects who were receiving public assistance, both as a source of income (from 42% at one year to 30% at three year) and as their major source of income (from 30% to 23%). In contrast to this trend, there was a steady increase in the proportion of subjects who were reliant on SSI as their major source of income (from 23% at one year post-discharge to 39% at three years). By the three year follow up contact, 46% were receiving SSI, as opposed to 24% at the one year contact. Another trend in financial support is that over time the group as a whole became less reliant on parents as a source of income. While 30% of the group reported receiving some financial assistance from parents at one year (22% as their major source of income) only 17% were receiving financial assistance from a parent at the three year contact (10% as their major source of income).

An analysis of variance *(F = 3.32, df = 76, p = .025)* indicated that SSI as a source of income at the three year contact differed significantly among diagnostic groups. While 64% of the thought disordered group and 53% of the conduct disordered group were receiving SSI, only 28% of the affective disordered group reported SSI as a source of income during the third year post-discharge.

Employment Status. The number of subjects who were employed increased slightly from twenty-eight (34%) at the one year follow-up to thirty-five (43%) at the three year follow-up. The proportion of employed subjects who were working full time (35 or more hours per week) went from 61% at the one year follow-up to 50% at the two year, and then to 71% at the three year follow-up (See Figure 4).

Over the 36 month course of the study period, twenty-seven subjects (39%) worked for less than 12 months, thirteen subjects (19%) worked between one and two years and seven subjects (10%) worked for more than 24 months. Twenty-two subjects (32%) reported never having been employed during the entire 36 month period.

Educational Attainment. By the three year follow up contact, 37% of the sample had obtained a high school diploma or G.E.D. An analysis of variance indicated a significant difference among the three diagnostic groups *(F = 5.06 df = 66, p=.003)* in educational attainment. Fifty three percent of the subjects with an affective disorder diagnosis had obtained a high school diploma or G.E.D. by the three year follow-up contact, while only 18% of the thought disordered group and 11% of the conduct disordered group had received a high school diploma or its equivalent.

Figure 2
Living With at 1, 2, & 3 Year Follow Up
Of Those Living in a Home

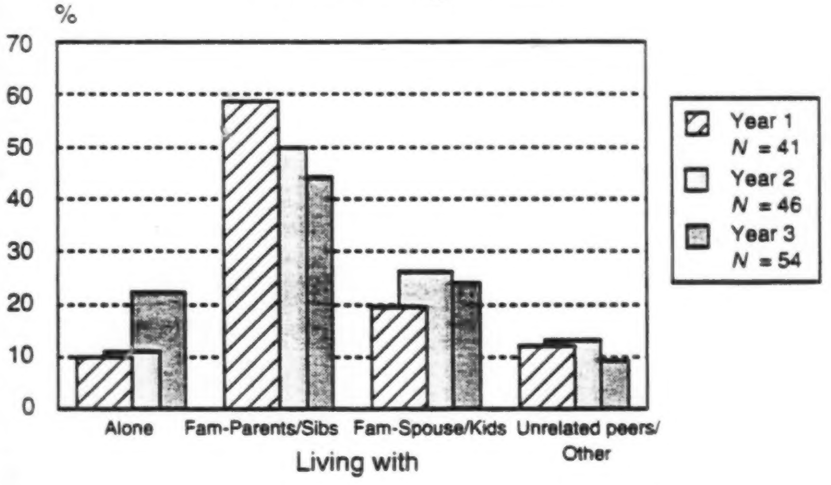


Figure 3
Financial Support 1-, 2- & 3-year Follow Up
N = 77

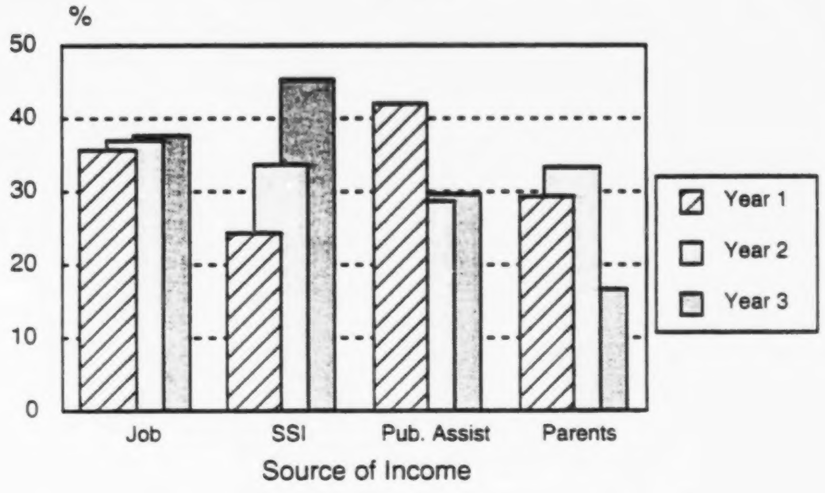
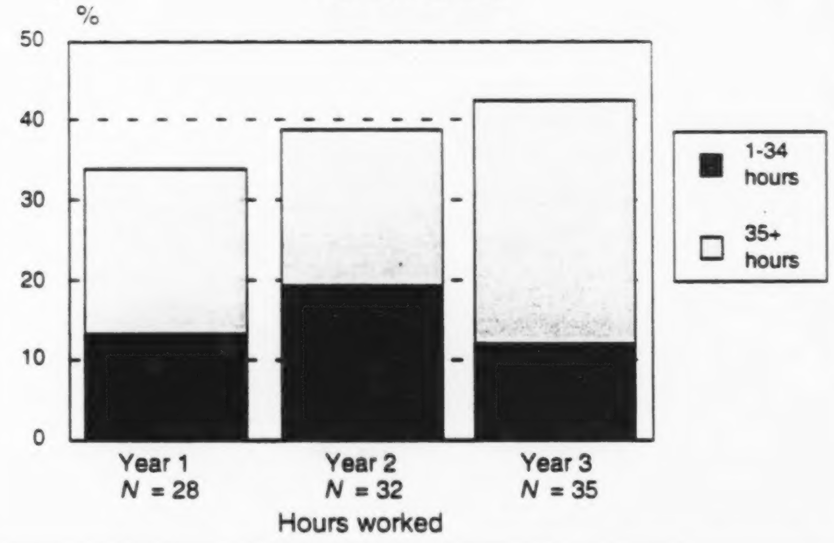


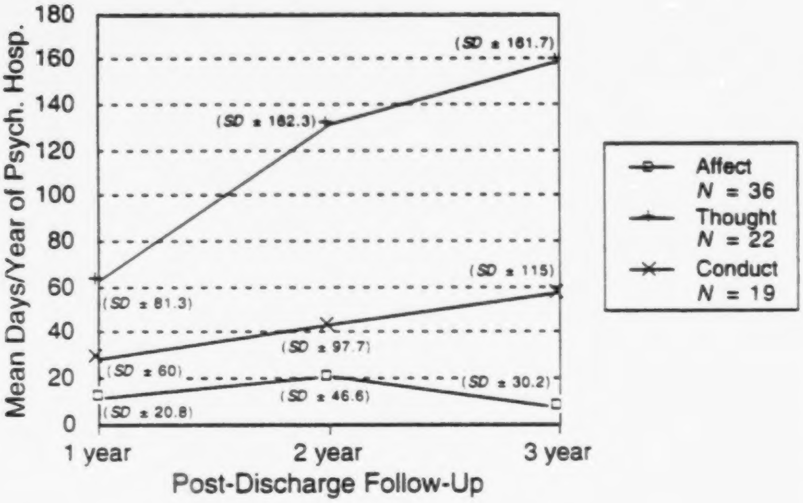
Figure 4
Employment
Part vs. Full Time



Mental Health Treatment.

As a group, the subjects in the McGraw Center Follow-Up Study had a mean of 1.92 psychiatric hospitalizations (*SD* = 2.2), and a mean of 126.2 days of hospitalization (*SD* = 312.5) between discharge from residential treatment and their three year follow-up anniversary. When differ- ences between diagnostic groups were exam- ined, there were no significant differences in the number of psychiatric hospitalization events between thought, affective and conduct disordered groups (an analysis of variance showed $F = .424$, $df = 73$, $p = .74$). There were, however, significant differences between the three diagnostic groups in the total number of days of hospitalization (analysis of variance: $F = 7.41$, $df = 71$, $p < .000$), with the thought disordered group showing a mean of 415.4 days hospitalized, a mean of 155.7 days hospitalized for the conduct disordered group and a mean of 55.9 days in the hospital for the affective disordered group (See Figure 5).

Figure 5
Days of Hospitalization
Year 1, 2, 3 Post-discharge



Discussion

It is interesting to compare the status of the United States 18-22 year old population as a whole, with the transition-aged youth of the McGraw Center Follow-Up Study. By the third year post-discharge, 43% of subjects in the study were employed, two thirds of whom were employed full-time. This is nearly comparable with their same age counterparts, according to 1980 U.S. Census estimates, of whom 55% are employed, two thirds of them full time. In sharp contrast, 22% of the youth discharged from residential treatment were living alone at the three year follow-up anniversary, while only 8% of their 20-24 year old counterparts were living alone. According to 1992 Census estimates, 15% of the population between the ages of 20 and 24 years were living in a mental hospital, compared to 17% in this sample of seriously psychiatrically impaired young adults.

Twenty-two percent of the McGraw Follow-Up transition-aged sample had graduated from high school, with another 15% completing a G.E.D. In the U.S. in 1980, 80.6% of 20 year-olds had graduated from high school. It is estimated that for children with serious emotional disturbances, 30% will complete high school.

Considering the serious degree of impairment in the McGraw Center study group, it is remarkable that as many of them finish school, find and sustain employment, and live on their own.

Our finding that the course of life is very different for young adults as a function of their diagnoses is also noteworthy. These findings imply that the needs during the transition period of the youth with affective disorders are different from the needs of youth with thought or conduct disorders. Anticipating these differences in life course enables us to plan appropriate supports tailored to the specific needs of each diagnostic group.

We are now able to compare the findings from the McGraw Center Follow-Up Study and the Transition Study which is part of the University of South Florida's National Adolescent and Child Treatment Study. We look to the future for multi-site collaborative research opportunities where similar methods and outcome measures are utilized. Such efforts will enable us to broaden and deepen our understanding of children and adolescents with serious emotional disorders.

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